TOWARDS A NEW UNDERSTANDING OF PSYCHOLOGICAL SUFFERING

By

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ABSTRACT

It is suggested that the lack of progress made towards understanding and preventing, or even in many cases even alleviating, psychological suffering has been due, in large part, to the way in which such suffering is conceptualised – as 'disorder', 'illness' or 'disease' which is located, and is thus potentially locatable, within the individual. This conceptualisation of psychological suffering is referred to in this thesis as the 'Dysfunctional Mind Account' (DMA). The DMA, it is argued, underlies all accepted models/theories of psychological suffering and is the dominant way of conceptualising such suffering for both professionals and lay-people in Western cultures. It is further argued that the main reason the DMA is unable to assist in understanding and alleviating psychological suffering is because it is underpinned by assumptions about human beings and their suffering which are inherently flawed.

The account presented in this thesis places at its centre an analysis of persons and their experience that attempts to overthrow these assumptions. The resulting reconceptualisation presents a view of psychological suffering as emergent from our continual personal and embodied enmeshment within our social world, rather than as arising primarily out of the various processes occurring 'within' us (whether that be our neurochemistry or our 'mental mechanisms' or an 'interaction' between them). It is essentially suggested that psychological suffering emerges from the same source as all other aspects of our personal being; from the constant coactions between the various aspects of our being in the world – personal, organismic and molecular – with the environment within which we are enmeshed.

This means that the feelings/thoughts/behaviours conceptualised as 'mental disorder' are as much part of our personal being as any other aspect of us; they are not 'other', they are not 'disease', 'illness' or 'dysfunction'. Such feelings/thoughts/behaviours, it is argued, almost always, perhaps inevitably, represent a very adaptive response, at every level of our being, to environmental contingencies. Thus, when understood in its full context, the suffering conceptualised as 'mental disorder' can be seen as the very understandable responses of the embodied person to what is happening to them, rather than 'un-understandable' dysfunctions, aberrations and pathological processes of the 'mind' (or brain).

INTRODUCTION

TOWARDS A NEW UNDERSTANDING OF PSYCHOLOGICAL SUFFERING

I spent day after day crying, huddled up in bed where I felt safe and could do no harm to myself. I could not concentrate to read or even watch television, and I did nothing for hours on end. My appetite disappeared, and I was constantly exhausted.

Kathryn (McNeil, 1993)

Voices, like the roar of a crowd came. I felt like Jesus; I was being crucified. It was dark. I just continued to huddle under the blanket, feeling weak, laid bare and defenceless in a cruel world I could no longer understand.

Stuart (Myers, 2001)

The mornings themselves were becoming bad now as I wandered about lethargic . . . but afternoons were still the worst, when I'd feel the horror, like some poisonous fogbank, roll in upon my mind, forcing me into bed. There I would lie for as long as six hours, stuporous and virtually paralyzed, gazing at the ceiling and waiting for that moment of evening when, mysteriously, the crucifixion would ease up just enough to allow me to force down some food and then, like an automaton, seek an hour or two of sleep again.

William (Styron, 1990)

That's when I first started hearing voices and having strange feelings. I got more and more stressed out. I was about twenty-four years old by then. It was quite bad, but I thought it was kind of special as well. I felt good when I was hearing those voices because I used to imagine that it was the boss at work talking to me. As if I was her child and she was telling me what to do.

Rosemary (Traynor, 1997)

I tried to tell him that I wasn't coping and I didn't enjoy my baby. That I was feeling alternately tearful and angry and thought I was going crazy. I had developed illogical behaviour and was obsessed by dirt. I was washing everything that fitted into the washing machine or sink . . . I eventually explained that I was sleeping three hours a night or less and I hated being a mum.

Fiona (Jeeves, 2004)

I cannot stand being awake. The pain is too much. I have had thoughts of suicide. I get depressed that I am old. Something has happened to me – this vital spark has stopped burning – I go to a dinner table now and I don't say a word, just sit there like a dodo.

Spike (Milligan & Clare, 1994)

The excerpts quoted above are all descriptions of what is commonly referred to as 'mental illness' or 'mental disorder'. It is generally acknowledged that the kinds of experience referred to by such terms are widespread (Eckersley, 2004; Horwitz, 2002a; Rothblum, Solomon, & Albee, 1986){Oakley-Browne, 2006 #785} and research also suggests that the incidence rates for such experiences are rising (Eckersley, 2004; Seligman, 1990). Indeed, Seligman (1990) concludes that in 1990 depression (one of the most common 'mental disorders') was ten times more common than it was fifty years before.

This rise in the levels of misery and distress is also reflected in rising suicide rates in Western societies (Eckersley, 2004; Public Health Group, 1996; Schumaker, 2001) with Schumaker (2001) pointing out that between 1960 and 1973 suicide rates doubled in the 15-24 age group in the United States and tripled for young black people. Epidemiological and anthropological research strongly suggests that these 'mental disorders' are less prevalent in 'developing' countries and that their incidence rises as societies become more ''Westernised' (see, for e.g., Schumaker, 2001; Warner, 1985). Indeed, some anthropological reports suggest that 'insanity' is rare or non-existent amongst peoples who have been completely unaffected by Western culture (Schieffelin, 1985; Torrey, 1973; Warner, 1985).

As Rothblum et. al. (Rothblum et al., 1986, p. 171) note, "according to most informed estimates some 15% of the population of the United States exhibits . . . serious emotional disturbances". Rothblum et. al. (1986, p. 171) further point out that this

> 'hard core group' does not include millions of persons with psychosomatic physical conditions . . . nor the very large number of other persons who experience acute emotional upsets as a consequence of life crises.

The reasons for such suffering, and for its apparent prevalence, remain the subject of much debate amongst mental health professionals and researchers and the search for a 'cure' for the many 'mental disorders' which have been identified remains ongoing. Indeed, it seems that the relief of 'symptoms' has been the primary achievement thus far, though, as has been pointed out by a number of authors, many of the 'symptoms' of most 'mental disorders' nevertheless remain entirely unrelieved (see, for e.g., Carson, 1996). This lack of progress is often openly acknowledged, particularly in reviews of the literature about mental disorders (Walker, Kestler, Bollini, & Hochman, 2004) wherein it is common to find such comments as:

> The progress in the area of affective disorders in the last two decades is impressive, but despite the availability of a myriad of antidepressants and psychotherapies that have been shown to possess unequivocal efficacy[1] in the treatment of depression, a large number of depressed patients remain ill. Clearly, advances in the management of depression would be welcome.
>
> (Nemeroff, 2001)

> We do not know the exact cause of bipolar affective disorder. Current theories see it as a diverse condition, possibly reflecting a number of separate underlying diseases. Different causes may operate in different people.
>
> (Mental Health Foundation, 1999b)

> Despite remarkable advances in the pharmacotherapy and psychotherapy of depression in the past two decades, the phenomenon remains an intriguing challenge to researchers. A definitive etiology is still unavailable, and diagnoses are frequently conflicting and inaccurate.
>
> (Carr & Vitaliano, 1985, p. 244)

> Even though a lot of research into ADHD has gone on around the world, its exact cause is still unknown. It is likely that there are not one, but several causes, which, when they occur together, become ADHD.
>
> (Mental Health Foundation, 1999a)

> All we really know is how to treat depression in the first six weeks. After that there's very limited understanding of what you do when the first treatment fails, how long people should be on medication – it's pretty much clinical folklore rather than real data.
>
> (Professor Roger Mulder, cited in Philp, 2001)

It is suggested that this lack of progress has been due, in large part, to the way in which such suffering is conceptualised in the first instance – as 'disorder', 'illness' or 'disease' which is located, and thus potentially locatable, 'inside' the individual. It will be argued that this conceptualisation, referred to in this thesis as the Dysfunctional Mind Account[2], underlies most generally accepted models or theories of psychological suffering and is the dominant way of conceptualising such suffering for both professionals and lay-people in Western[3] cultures.

It will be argued in Chapter Two of this thesis that this conceptualisation is inherently flawed at a theoretical level, and has very little empirical support. It will be

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[1] This is a highly contested statement (see Breggin, 1991; Ross, 1995a; Whitfield, 2004; Kirsch et al., 2008).
[2] The reasons for this will be discussed in some detail in Chapter One.
[3] Note that this approach is at its most undiluted in America and that while it is still 'mainstream' in Britain and in Europe it is more contested in these countries (see Gaines, 1982; Sanua, 1993) due to different socio-cultural forces.

further suggested that at a practical level such a conceptualisation leads to the search for both causes and 'cure' being focused primarily 'inside the skin' of the individual; a partial approach which leads to only partial and often misleading results. This critique will lay the groundwork, and provide the rationale for, the attempt in the remaining chapters of this thesis to reach an understanding of psychological suffering that does not locate it solely within the individual, but which does not deny the personal 'embodied' nature of such suffering.

Before proceeding any further, however, it should be noted that when referring to the kinds of experiences usually called 'mental disorder' or 'mental illness' I will, in most instances, use the phrase 'psychological suffering'. [4] The word 'suffer' derives from the Latin *suffero*, to suffer – *sub*, under and *fero*, to bear. To suffer is "to feel or bear with painful, disagreeable, or distressing effects; to undergo (to suffer pain)" (Thatcher & McQueen, 1952, p. 838). Because suffering is perhaps the most fundamental aspect of the vast majority of those behaviours and experiences commonly called 'mental disorders'[5] to refer to such experiences as 'suffering' is relatively unproblematic, if unspecific. Importantly it implies no judgements or assumptions about the 'location' or the etiology of these experiences.

To call such suffering 'psychological' is also relatively unproblematic, as long as the word *psychological* is used to refer simply to a person's activities in the world[6] rather than to some kind of Cartesian mental space[7] entirely separate from the physical or somatic. If the word 'psychological' is used in this way then the phrase 'psychological suffering' also implies no assumptions about the location or the etiology of the experiences it refers to.

Of course 'psychological suffering' is a very general term, encompassing not only 'mental disorders' but so-called 'normal' reactions to life's vicissitudes (e.g., grief, shock, sadness, frustration, guilt, jealousy[8], etc.). In general, the phrase 'psychological suffering', in the context of this thesis, will refer to those experiences usually called 'mental disorder', although, as will be discussed in some detail in Chapter Two, the boundary line between what is 'disordered' and what is 'normal' is blurred and

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[4] Unless I am quoting directly or indirectly from other sources.
[5] There are, of course, a handful of 'mental disorders' listed in the DSM-IV which, it could be argued, do not seem to involve overt suffering, at least on the part of the 'disordered' person, for e.g., antisocial personality disorder and conduct disorder. Such disorders are, however, far outnumbered by those 'disorders' to which suffering is central.
[6] Meaning both those activities referred to by psychologists as 'mental' (thinking, believing, dreaming, remembering, etc.) and as 'behavioural' (talking, crying, sleeping, screaming, etc.). In lived experience the 'mental' and the 'behavioural' are probably impossible to separate.
[7] Indeed, as will become clear, this thesis is fundamentally opposed to such a position.

constantly moving (posing a constant problem for those who believe in the reality of 'mental disorders'). Indeed, this thesis will suggest that the psychological suffering identified as 'mental disorder' is not of a fundamentally different kind from the psychological suffering seen as 'normal' or nondisordered; rather, it is a matter of increased intensity or duration. This point is essentially acknowledged by the DSM-IV (American Psychiatric Association, 1994), given that many disorders begin, or are identified, when 'normal' suffering goes on past a certain length of time, or exceeds a certain level of intensity.

Chapter Outline

Chapter One

It will be argued that the Dysfunctional Mind Account underlies all accepted models or theories of psychological suffering and is the dominant way of conceptualising such suffering for both professionals and lay-people in Western cultures.

Chapter Two

It will be argued that the Dysfunctional Mind Account is inherently flawed at a theoretical level and has very little empirical support. It will be further argued that this due to the Account being underpinned with assumptions about human beings and their suffering which are also inherently flawed.

Chapter Three

An approach to understanding human experience, which could be characterised as 'social constructionist' in its orientation, will be presented which overturns these assumptions and in so doing overturns the notion of the "atomistic, bounded, coherent, rational psychological subject endorsed at least implicitly, by most mainstream approaches" (Cromby, 2004a, p. 797). I will draw primarily upon the theorising of Rom Harre, John Shotter and John Cromby whose work is particularly useful within the context of this thesis because of their focus on the social construction of our experience of being persons in the world, our 'personal being' as Harré (1984a) refers to it.

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[8] Though all of these can easily spill over into becoming 'disorders' or at least symptoms of 'disorders' if they go on 'too long' or are 'too extreme'.

Chapter Four

In this chapter it was acknowledged that the emergence of persons and their suffering cannot be understood only by looking at sociocultural and discursive factors because persons are both socioculturally and biologically co-constituted. In order to facilitate a clearer articulation of the ways in which this co-constitutional process occurs a brief outline of the developmental approach to biology taken by Steven Rose (1997) will be provided before discussing some recent research from the biological sciences illustrating Rose's (1997) central contention – that the lifeline of an organism is constructed via its enmeshment in its environment, and thus cannot be understood without taking that environment into account – an insight which mirrors the social constructionist position that a person cannot be understood separately from the social world within which s/he is enmeshed.

Chapter Five

An account will be sketched out which will describe how the feelings/ thoughts/actions which are conceptualised as 'symptomatic' of the various 'mental disorders' are emergent from our continual personal and embodied enmeshment within our social world, rather than arising from processes occurring within us (whether those processes be neurochemical or 'mental').

Chapter Six

In this chapter more detailed analyses will be presented of how, given the vagaries of each person's particular life trajectory, two particular 'clusters of suffering' – conceptualised as 'schizophrenia' and 'depression' – may emerge.

CHAPTER ONE

THE DYSFUNCTIONAL MIND ACCOUNT OF PSYCHOLOGICAL SUFFERING

1.1. INTRODUCTION

Many within the mental health field suggest that there is no one dominant way of explaining or understanding psychological suffering (e.g., Clare, 1976; Myers, 2001; Shorter, 1997; Wing, 1978). Those who take this position claim that mental health professionals are essentially eclectic in their approach to such suffering, selecting amongst a wide variety of 'models' and methods and tailoring both their aetiological assumptions and their therapeutic efforts to the needs of each individual client.

It is further claimed that the multiple ways currently available for conceptualising and explaining psychological suffering are almost all, to varying degrees, useful, both practically and theoretically, particularly if some sort of synthesis can be achieved between them. This new drive for synthesis is reflected in the current enthusiasm for the "interdisciplinary bio-psycho-social perspective" (Myers, 2001, p. 534), sometimes referred to as the 'multi-causal model' (Gleitman, Fridlund & Reisberg, 2004). This approach will be discussed in more detail below.

As will be shown in Section 1.3, however, underlying all the 'mainstream[1]' approaches to psychological suffering, including the biopsychosocial model, is the assumption that certain manifestations of such suffering[2] are objectively verifiable 'mental disorders', 'mental illnesses or 'mental diseases[3], and that these problems exist

[1] By 'mainstream' I mean those approaches which have the backing of the major institutions set up within our society to deal with such suffering; the professional disciplines of psychiatry and clinical psychology, the research carried out by those involved or associated with these disciplines and the organisations to which members of these professions belong (e.g., The American Psychiatric Association, The National Institute of Mental Health, The New Zealand Psychological Society, The Royal Australian and New Zealand College of Psychiatrists).

[2] Usually those that are particularly intense, long lasting or disruptive to the person's life and/or to the wider community within which they live.

[3] There are a number of referents to such suffering which are essentially variations on the internal dysfunction / pathology theme; for e.g., 'psychiatric disorder', 'psychiatric illness', 'psychiatric disease', and 'psychopathology'.

inside the skin of each individual sufferer. Such 'disorders' can be researched, discussed, debated about, managed, treated and sometimes even cured in more or less the same way as physical illnesses can.

Essentially this way of conceptualising psychological suffering is grounded in what is known as the 'medical-model' (sometimes also referred to as the 'disease model'). Busfield (1986, p. 16) notes that the terms 'medical model' and 'disease model' are commonly used to refer to a view of psychological suffering that "locates its significant causes and treatments exclusively within the realm of the body". Svensson (1995, p. 5), a critic of this orientation, notes that the medical model contains two central assumptions

1. that the phenomena called mental illnesses are sufficiently like the phenomena called 'ordinary', or bodily, illnesses for the two categories to be subsumed under a common head-category, and
2. that the two types of phenomena are sufficiently dissimilar to motivate the separation of them into two distinguishable sub-categories

Svensson (1995, p. 5) further notes that the

> espousing of the medical model . . . most often is tied to the notion that 'mental illnesses are like any other illnesses'; they are entities or processes located within the ill person, causing suffering and incapacitation; and just like any other illnesses they could, and should, be diagnosed and treated by medical expertise.

As Blashfield (1984, p. 26, all italics in original, cited in Follette & Houts, 1996) points out, the medical model carries with it implicit notions about the 'management' and treatment of those who suffer psychologically due to its conceptualisation of such suffering as 'disease'. Thus

> the persons afflicted with these diseases are called *patients*; they need treatment from *doctors*; *diagnosis* is an essential first step if one is to prescribe the best *therapy* and to predict the natural *course* of a patient's disorder. Severely disturbed patients need *medication* and perhaps *hospitalization*; their care should be paid for by *health insurance policies*.

Svensson (1995, p. 64) suggests that 'the medical model' is probably "the most frequently used expression in the polemics concerning 'mental illness'". It is the application of this model to the problems and experiences called 'mental illness' that has been, and continues to be, the target of most critiques, and it is this model that the defenders of the concept of 'mental illness' defend.

The term 'medical model', however, as Busfield (1986, p. 16) points out . . . "has become a shorthand for a set of ideas about mental illness and psychiatry whose content is rarely specified. As a result it's meaning has become extremely vague and imprecise". Svensson (1995) notes that there are at least two main understandings of the medical model as applied to psychological suffering; one that explains psychological suffering as the result of biological abnormalities and disturbances, and one that characterises psychological suffering *as if* it were illness or disease.

Svensson (1995) distinguishes between these two understandings by referring to the first as the somaticist version of the model, and the second as the metaphorical version. Indeed, many critics of the 'medical model' are actually criticising the narrow biological version of the model , but are still happy to accept the *as if* or 'metaphorical' medical model explanation of psychological suffering (e.g., Clare, 1976, Engel, 1980, cited in Pilgrim, 2002).

Svensson (1995, p. 66) notes that the medical model (in both its guises) tends to focus on "the cause side of the health-disease complex" and arguments offered by the proponents of this version "come close to what might be described as sophisticated versions of . . . "the faulty machine model" of disease[4]. While there have been attempts to break away from the medical model altogether and offer models which focus more on the effects or consequences side (see Svensson, 1995, p. 66-67) it is the medical model in both its somaticist and metaphorical guises which dominates psychiatry, and the wider mental health field today (as will be illustrated in Section 1.2 below, and discussed further in Chapter Two).

It should be noted here that the new 'biopsychosocial' or multi-causal approach advocated by many of those who have criticised the somaticist medical model of psychological suffering is still a traditional medical model account; the only difference being that it embraces both a somaticist and a metaphorist approach rather than opting for one or the other. Because of the lack of conclusive evidence that any 'mental illness' is caused by malfunctioning biology, however, proponents of the biopsychosocial model are often forced back into a more metaphorist position to justify the labelling of a wide range of problems as 'mental disorder' or 'mental illness' (See Chapter Two).

The biopsychosocial position is articulated most clearly by its founder, George Engel (1980). Engel argued that mental disorders (like other medical disorders) emerge within individuals, but that those individuals are also part of a larger system. This

[4] Indeed, many influential proponents of this approach to psychological suffering are quite open about such suffering being due to 'dysfunctions' occurring within the person as will be discussed further in Chapter Two.

larger system has physical elements that are both sub-personal (biological) and supra-personal (social and physical environment). This system is conceptualised hierarchically; the lower levels are necessary for the existence of the higher levels, but they are not sufficient to describe or explain them.

Pilgrim (2002, p. 586) notes that the biopsychosocial model "was established as a form of psychiatric orthodoxy" by the 1970s and that it has been particularly useful as a means of deflecting the criticisms of the 'anti-psychiatrists'. As Pilgrim (2002, p. 586) points out,

> Virtually all of the disquiet created by psychiatry since the Second World War has emanated from a constellation of factors within a reductionist biomedical orthodoxy . . . The psychiatric professional agenda has constituted a wide target to hit by critics and the BPS model provides the means to significantly reduce its size.

While some critics claim that the biopsychosocial model "has been relegated to political lip service in our managed care era" (Gabbard & Kay, 2001), and that many of its psychiatrist followers have "relapsed into a crude bio-determinism in their clinical work" (Pilgrim, 2002, p. 586), the model is nevertheless still widely touted as being the way forward for the mental health field (Clare, 1999; Gabbard & Kay, 2001; Myers, 2001).

Non-psychiatric mental health professionals such as clinical psychologists, social workers and counsellors of various persuasions particularly favour the biopsychosocial approach. It is also still popular amongst psychiatrists who are not determinedly bioreductionist; allowing them to continue to conceptualise certain problems as 'mental illness', despite the absence of any indication that these problems have biological causes (e.g., Clare, 1976, 1999).

Gaines (1982, p. 171) makes an important point about the biopsychosocial approach in his study of the relation of psychiatrists' definitions of 'mental illness', seen as folk theories, to professional behaviour. He notes of one of his subjects;

> Dr Lauren, however, felt that mental disorders could be caused by biogenic, macro- or micro-sociogenic or psychogenic factors. This view is not a kind of holistic view as that held by Dr Sohm in my first study. Rather, Dr Lauren was asserting that any and/or all of these sorts of factors could be causal agents. Basically, he was asserting an open position, rather than a holistic view.

This seems to accurately encapsulate the 'biopsychosocial' approach as practised by mental health professionals currently. For those who espouse this approach the causal factors of 'mental illness' may be biological, or psychological, or social. Alternatively, such 'illnesses' may be caused by an 'interaction' between these factors. Such an approach still divides the biological, the psychological and the social into

categories that may 'interact' with each other but are nevertheless separate, and separable by science.

Indeed, the biopsychosocial approach seems to share the underlying assumption of what Ingold (2000) refers to as the 'complementarity thesis'; an account of the human being as "a creature of three components, of genotype, mind and culture". As Ingold (2000, p. 231) points out, the approaches to these three components, drawn from biology, cognitive psychology and anthropology, share one fundamental premise "that the bodily forms, intellectual capacities and behavioural dispositions of humans are specified independently and in advance of their involvement in practical contexts of environmental activity".

The biopsychosocial approach often results in mental health professionals 'sliding' between different discourses about psychological suffering (biological, psychological and social/ environmental) depending on the situation at hand. Barrett (1996) suggests that this is particularly so for psychiatrists who, while claiming specialist expertise about the 'mind', now have considerable competition from other professionals for this 'work-site' and so tend to "fall back on [their] medical stronghold, the body". Barrett (1996, p. 48) further notes that it is

> largely a matter of psychiatric discretion to determine the relative mix of body and mind for each case and to adjudicate . . . on whether a stressful emotional state triggered a biological illness or that illness caused the emotional state in the first instance.

Despite the apparent openness of the biopsychosocial model to the possibility of 'mental disorders' having multiple causal pathways it still tends to function primarily as a biological model for many of its supporters (Pilgrim, 2002). The biological is seen as the point of 'first cause' and the psychological and the social are seen as 'triggers' of that underlying 'predisposition'.

As Nicolson (1991/1992) and Rose (1986) point out, even more socially oriented theories which claim to reject the medical model (in all its forms, including the biopsychosocial) often continue to pathologise psychological suffering. Nicolson (1991/1992, p. 78), discussing depression in women following childbirth, notes that both the social science account and the clinical/medical account of such suffering employ the view that 'post-natal depression'

> can (a) be made available to an 'objective identification', and (b) is distinct in its quality from other forms of depression that might be experienced by men or women at times other than following childbirth.

Pilgrim and Bentall (1999) draw attention to the work of George Brown and colleagues (Brown & Harris, 1978, p. 20) on the social origins of depression as being a

good example of this retention of medical model assumptions within a socially based theory. Indeed, Brown has made it clear that he believes there is a biological base to 'depression' the illness that is different from everyday misery. Ingleby (1980) likewise notes that Brown's work is a version of "weak positivism" because of its uncritical retention of the diagnostic category of depression.

Kleinman (1988; 1997; 1985), a psychiatrist and anthropologist whose theorising about 'mental disease' is also strongly social in its orientation, also argues that many of the more serious 'mental disorders' may be caused by disordered biology, with social/environmental factors triggering their onset and either exacerbating or alleviating their course (see, for e.g., Kleinman, 1988). Indeed, as Busfield (1986, p. 15) points out

> Much of the conflict about the causes of mental illness . . . and about preferable treatments occurs within this [medical model] framework and does not question its basic parameters.

It is important to note that this thesis is challenging both versions of the medical model as articulated by Svensson (1995); the somaticist and the metaphorical. It is also challenging the 'biopsychosocial' accounts which attempt to combine the two into a more integrated model of mental health and illness and those social science accounts which continue to pathologise or implicitly medicalise psychological suffering.

Rather than referring to the 'medical model account', the 'disease model account' or the 'clinical/medical account', however, this thesis will refer to such conceptualisations of psychological suffering as the 'Dysfunctional Mind Account' (DMA). This avoids the implication that it is only the medical or biological approach to such suffering that is at issue here. It also highlights the assumption – underlying all ascriptions of 'mental illness' or 'mental disorder' – that people's suffering is the result of something going wrong with the natural or 'normal' functioning of their 'minds' (often conflated with the brain in biological accounts). It is this assumption that will be the primary focus of criticism in this thesis.

Indeed, as Wakefield (1992b, p. 381), a prolific and widely cited defender of the concept 'mental disorder' notes, there is a "virtually universal tendency to fall back on dysfunction to explain disorder". Wakefield (1992b) further points out that the notion of 'dysfunction' occurs "with remarkable consistency in the remarks of many authors who otherwise differ in their views" including Spitzer and Endicott (1978, cited in Wakefield, 1992b), two of the leading architects of the American Psychiatric Association's

Diagnostic and Statistical Manual[5] (American Psychiatric Association, 1994, 2000). According to Wakefield, 1992, p. 381) Spitzer and Endicott "noted the seeming necessity and virtual universality of using dysfunction to make sense of disorder". Wakefield himself has argued in an influential and widely cited series of papers (Wakefield, 1992a, 1992b, 1996, 1997a, 1997b, 1999a, 1999b, 2002) that a problem cannot be a 'mental disorder' unless it can be established that it is due to the dysfunction of some underlying 'mental mechanism'.

Klein (1987, cited in Follette & Houts, 1996) has also argued for the importance of dysfunction as the basis for the concept of disease as applied to 'mental disorders'. As Klein (1987, cited in Follette & Houts, 1996, p. 70) points out

> [m]odern science has developed the concept of objective underlying disease processes, demonstrating that the inference that something has gone wrong is not simply arbitrary. Disease is defined here as covert, objective, suboptimal part dysfunction.

This notion of the dysfunctioning mind underlies not only all biomedical accounts of psychological suffering (despite the use of the word 'brain' in place of 'mind' in these accounts), but also all psychological and most psycho-social accounts (including the 'biopsychosocial' accounts). The only exception to this is psychoanalytic[6] approach wherein 'psyche' is social and formed through interactions with others.

1.2. THE DOMINANCE OF THE DYSFUNCTIONAL MIND ACCOUNT

This thesis contends that the approach to psychological suffering referred to in this thesis as the Dysfunctional Mind Account (DMA) – that is the idea that certain forms of intense or long-lasting psychological suffering are the result of a dysfunctioning mind (or brain) – dominates the way in which psychological suffering is conceptualised in Anglo-American[7] cultures. Before going on to discuss the limitations

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[5] A widely used diagnostic system developed by the American Psychiatric Association (see Chapter Two, Section 2.2.1)

[6] I am referring here to the post-Freudian approaches such as the Lacanian, and some Kleinian versions of psychoanalysis, *not* to the 'psychoanalysis' that was imported into American psychiatry and radically revised in the process.

[7] According to Gaines (1982, p. 178) there are "two distinct major cultural traditions in the West" – the Mediterranean-Latin tradition and the Northern Europe-Protestant tradition. The Northern-European tradition "is home to the world-view Weber (1964, cited in Gaines, 1982, p. 179) referred to as 'disenchanted'" and takes a "practical, empiricist, non-magical approach to the world" (Gaines, 1982, p. 179). It is in the latter that underlies the world-view that dominates Anglo-American societies (including

of the DMA, however, it is important to demonstrate the veracity of the claim that the approach to psychological suffering I am calling the DMA[8], far from being the 'straw man' that many defenders of the account suggest (e.g., Clare, 1976; Shorter, 1997; Wing, 1978), exists in, and indeed underpins, all 'mainstream' responses to psychological suffering.

1.2.1. The DMA in professional discourse about 'mental health'

The primary disseminator of the Dysfunctional Mind Account is the *Diagnostic and Statistical Manual of Mental Disorders*, first published by the American Psychiatric Association in 1952 (DSM) (American Psychiatric Association, 1952) and now in its fourth edition – revised (DSM-IV-TR) (American Psychiatric Association, 2000). The DSM[9] is now one of the most widely used, and certainly the most influential, psychiatric diagnostic systems in the world (Bentall, 2004; Caplan, 1995; Follette, 1996; Follette & Houts, 1996; Hare-Mustin & Marecek, 1997). As Caplan (1995, p. xviii) notes

> Today, in most settings where new generations of psychiatrists and other physicians, social workers, psychologists, and psychiatric nurses are trained the DSM is the key volume about mental illness that all trainees must learn from cover to cover. It is also used as the key volume for a great deal of the research on mental health and mental illness funded by government agencies and private foundations.

While its dominance is most complete in the United States the DSM system is also widely used in other countries around the world (Kirk & Kutchins, 1992; Pilgrim & Rogers, 1999). A commonly used alternative to the DSM system in some countries is the World Health Organisation's *International Statistical Classification of Diseases and Related Health Problems* (known by the acronym ICD). The problems listed in the 'Mental Disorder' section of the latest version of the ICD (ICD-10) (World Health Organization, 1990) are very similar, however, to those listed in the DSM-IV. Indeed, a lot of effort was expended during the preparation of the ICD-10 to make sure that the diagnostic categories listed within lined up with those in the DSM-IV. This has considerably widened the influence of the DSM system and the Dysfunctional Mind Account of psychological suffering it promulgates.

Australia, NZ, Canada, etc.) and it is out of this world-view that psychiatry emerged in the nineteenth century.

[8] Which other critics have variously referred to as the 'medical model', the 'disease model', the psychiatric model, or 'diagnostic psychiatry'.

[9] I could have called the approach to psychological suffering at issue in this thesis the DSM account but decided not to because a significant number of researchers and professionals are clearly in support of the main tenets of the Dysfunctional Mind Account (see p. 2, this chapter) but are very critical of the DSM (e.g. Wakefield, and others)

As will be further discussed in Chapter Two, all editions of the Manual since DSM-III (American Psychiatric Association, 1980) note that to qualify as a 'mental disorder' a person's suffering

> must currently be considered a manifestation of a behavioral, psychological, or biological dysfunction in the individual. Neither deviant behavior (e.g., political, religious, or sexual) nor conflicts that are primarily between the person and society are mental disorders unless the deviance or conflict is a symptom of a dysfunction in the person.

The DSM then lists a large number of 'mental disorders' and provides outlines of the symptoms that signal the presence of these disorders. As will be discussed further in Chapter Two, although these 'disorders' have surprisingly little theoretical or empirical support as scientific concepts they are taken as 'a given' by the vast majority of researchers and practitioners in the mental health field simply because they are listed in the DSM (Follette, 1996).

It should be noted at this point that the first two editions of the Manual were strongly psychoanalytic in their approach and terminology and there was no set dividing line between normal and abnormal. The DSM-III (American Psychiatric Association, 1980) marked a radical shift towards the more biomedical paradigm that had been dominant in the nineteenth and early twentieth centuries (Busfield, 1986). As Bentall (2004, p. 58) points out, by the end of the 1960s

> many American psychiatrists had become disenchanted with psychoanalysis, partly because it had failed to deliver effective treatments but also because it threatened to sever forever the ties between psychiatry and medicine.

This was primarily due to major problems with the reliability and validity of the 'disorders' described in the DSM-I and II; a problem so profound it was threatening to undermine the legitimacy of psychiatry as a medical discipline (Kirk & Kutchins, 1992; Bentall, 2004). In order to put an end to this slide into professional oblivion a group of psychiatrists, headed by Robert Spitzer joined forces to cleanse the DSM system of psychoanalytic jargon and to return psychiatry to its medical roots.

Gerald Klerman (1978, cited in Bentall, 2004), a high-ranking psychiatrist in the Federal Government and ardent supporter of the DSM-III, coined the term *neo-Kraepelinian* to describe the new attitude to psychological suffering advocated by this movement. The term *neo-Kraepelinian* refers to a return to the approach advocated by one of psychiatry's founding fathers, Emil Kraepelin who, as Bentall (2004, p. 42) notes, "established a paradigm or a set of assumptions" which stated that

> psychiatric disorders fall into a finite number of types of categories (dementia praecox, manic depression, paranoia, etc.), each with a different pathophysiology and aetiology.

Klerman (1978, cited in Bentall, 2004) outlined the nine propositions that he believed united this new movement. These nine propositions, particularly propositions 4, 5, 7, 8 and 9, reflect the Dysfunctional Mind Account in action and are fundamental to the approach taken to psychological suffering by the DSM. They are:

1) Psychiatry is a branch of medicine.
2) Psychiatry should use modern scientific methodologies and base its practice on scientific knowledge
3) Psychiatry treats people who are sick and who require treatment for mental illness.
4) There is a boundary between the normal and the sick.
5) There are discrete mental illnesses. Mental illnesses are not myths. There is not one, but many mental illnesses. It is the task of scientific psychiatry, as of other medical specialities, to investigate the causes, diagnosis and treatment of mental illnesses.
6) The focus of psychiatric physicians should be particularly on the biological aspects of mental illness.
7) There should be an explicit and intentional concern with diagnosis and classification.
8) Diagnostic criteria should be codified, and a legitimate and valued area of research should be to validate such criteria by various techniques. Further, departments of psychiatry in medical schools should teach these criteria and not depreciate them, as has been the case for many years.
9) In research efforts directed at improving the reliability and validity of diagnosis and classification, statistical techniques should be utilized.

For Klerman (1984, p. 539, cited in Kirk & Kutchins, 1992, p. 6) the DSM-III represented a "significant reaffirmation on the part of American psychiatry to its medical identity and its commitment to scientific medicine". He concluded his speech at a national convention between proponents and critics of the new manual in 1982 by suggesting that

> The judgment is in; DSM-III has already been declared a victory. There is not a textbook of psychology or psychiatry that does not use DSM-III as the organizing principle for its table of contents and for classification of psychopathology. The debate is already an anachronism. The victory of DSM-III has been acknowledged by our

> colleagues and adversaries in psychopathology, in the other mental health professions and in other countries.
>
> Klerman (1984, p. 542, cited in Kirk & Kutchins, 1992, p. 6)

Not surprisingly, given the influence of the Manual, the approach to psychological suffering advocated by the architects of the DSM is strongly evident in almost all mainstream professional discourse about psychological suffering. A glance through top mainstream journals of psychiatry[10] and clinical psychology[11] certainly confirms this.

In almost every article it is taken as a given that the suffering being discussed is the manifestation of one particular (or sometimes more than one) 'mental disorder' (Proposition 5). It is also largely taken as a given that there is a clear dividing line between the 'mentally ill' and the 'mentally well' (Proposition 4). Also evident in mainstream journals is an abiding interest in issues surrounding diagnosis and classification (Proposition 7). Of particular interest is the effort to determine the validity and reliability of the diagnostic criteria for the various disorders contained within the DSM (Proposition 8) and various complicated statistical techniques are utilised to this end (Proposition 9).

The Dysfunctional Mind Account, as promulgated by the DSM, is also reflected in books written primarily for the use of practising mental health professionals also reflect the Dysfunctional Mind Account of psychological suffering. A representative example is *The Hatherleigh guide to Psychiatric Disorders* (Hatherleigh Press, 1996), which describes itself as surveying "a fascinating array of emotional and behavioural disorders encountered in contemporary American culture". *The Hatherleigh guide* uses the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 1994) as its framework for discussing each of the 'disorders' it canvasses.

Textbooks written for those studying to become psychiatrists and psychologists are also indicative of the all-encompassing nature of the DMA in the mental health field (suggesting that the second point in Proposition 8 has been taken to heart). The following quotes are taken from textbooks, introductory and advanced, of general psychology, abnormal psychology and psychiatry.

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[10] American Journal of Psychiatry, Archives of General Psychiatry, American Journal of Orthopsychiatry, British Journal of Psychiatry, Canadian Journal of Psychiatry, Australian and New Zealand Journal of Psychiatry

[11] British Journal of Clinical Psychology, British Journal of Abnormal Psychology, Journal of Abnormal Psychology, Journal of Abnormal Child Psychology, Journal of Clinical Psychology, Journal of Consulting and Clinical Psychology

Scientific research continues to increase our understanding of the human mind. Recent findings have shed new light on the development of the mind, on its complex relationship with the body, and on the diagnosis and treatment of its disorders.

The Harvard Guide to Psychiatry (Nicholi, 1999, p. 1)

Abnormal psychology is devoted to the study of mental, emotional, and behavioural aberrations. It is the branch of psychology, concerned with research into classification, causation, diagnosis, prevention, and treatment of psychological disorders or psychopathology. Its purview covers a broad spectrum of afflictions and includes neuroses, psychoses, personality disorders, psychophysiological disorders, organic mental syndromes, and mental retardation.

Abnormal Psychology (Lazarus & Colman, 1995, p. ix)

A prominent concern in abnormal psychology has been the presence of 'psychological deficit', which can be defined as a decrement in psychological functioning, usually as assessed by intellectual or laboratory tasks, as a result of a particular clinical disorder.

Investigating Abnormal Behaviour (E. Miller & Morley, 1986, p. 55)

There is a need for instruments that will identify a disorder like depression and which will measure the degree to which subjects possess this attribute.

Investigating Abnormal Behaviour (E. Miller & Morley, 1986, p. 55)

We turn now to a different sort of variation, one that is a departure from normal functioning and that carries us into the realm of mental illness. The study of such conditions is the province of psychopathology, or, as it is sometimes called, abnormal psychology.

Psychology (Gleitman, Fridlund, & Reisberg, 2004, p. 642)

The medical model's assumption that psychological disorders are mental illnesses displaced earlier views that demons and evil spirits were to blame. However, critics question the medical model's labelling of psychological disorders as sicknesses. Most mental health workers today adopt a bio-psycho-social perspective. They assume that disorders are influenced by genetic predisposition, physiological state, psychological dynamics and social circumstances.

Psychology (Myers, 2001, p. 537)

The first quote, from *The Harvard Guide to Psychiatry*, encapsulates the Dysfunctional Mind Account[12] approach to psychological suffering. It identifies the 'mind' as the thing that is 'disordered' and thus the entity that should be the focus of treatment and enquiry. It also suggests that this 'mind' can be understood by application of the scientific approach.

Indeed, as Busfield (1986, p. 17) notes, the application of science to understanding the 'mind', is

> viewed as the lynchpin of psychiatric practice; it is science that permits the boundary to be drawn between the normal and the pathological; it is science that creates the possibility of accurate identification of the mentally ill; it is science that provides sound knowledge of the causes of mental illness; and it is science that provides effective methods of cure. Consequently, it is science that determines the essential content and form of psychiatric practice, what help is offered, where it is offered, and who receives it.

It is important to note here that the word 'scientific' is used by psychiatry for rhetorical purposes; the approach taken to psychological suffering by psychiatry is anything but scientific in the real sense of the word (Bentall, 2004; M. Boyle, 2002). The application of a truly scientific approach would not 'permit the boundary to be drawn between the normal and the pathological', nor help us to accurately identify the mentally ill as these are value judgements not matters of scientific fact (Boyle, 2000; Bentall, 2004).

As will be discussed Chapter Two, there is very little research of a 'scientific' nature being applied to the causes and cures of those types of psychological suffering seen as 'mental illness'. As will also be discussed in Chapter Two it is not 'science' that determines "the essential content and form of psychiatric practice, what help is offered, where it is offered, and who receives it".

The general assumption of the 'disordered' or 'dysfunctional' mind best understood and treated by the 'scientific' approach is implicit in all of the general psychology (Atkinson, Atkinson, Smith, Bem, & Nolen-Hoeksema, 1996; Gazzaniga & Heatherton, 2003; Gleitman et al., 2004; Myers, 2001; Weiten, 2004), abnormal psychology (Barlow & Durand, 2002; Coles, 1982; Davison, Neale, & King, 2004; Hersen & van Hasselt, 2001; Lazarus & Colman, 1995) and psychiatry texts (Guthrie & Lewis, 2002; Nicholi, 1999; Tasman, Kay, & Lieberman, 2003) surveyed, although the medical or disease model variant of it was subjected to a more critical appraisal in psychology texts than it is in psychiatry texts, as the quote from Myers (2001), above, illustrates. Even when criticising the approach characterised as the 'medical model' (usually meaning the

[12] Note that this quote could be interpreted as being in favour of the both versions of the medical model as outlined by Svensson (1995, see Section 2.1)

biological version of the model), however, all these texts continue to refer to psychological suffering as 'mental disorder' or 'psychological disorder' and to primarily characterise such suffering as a dysfunction internal to the sufferer.

Pilgrim and Bentall (1999, p. 264) note that "psychologists are more prone to assume the continuous distribution of personality features and psychological functioning, including depressive experience (e.g., Eysenck, 1986), whereas psychiatrists are more likely to argue that illness is a category or discontinuous state (e.g., Kendell, 1975)". Nevertheless, most clinical psychology texts almost invariably characterise psychological suffering as 'mental disorder'. Many such texts are divided into chapters devoted to the aetiology, course and treatment (medical terminology) of each individual 'mental disorder' (as listed in the DSM). These disorders are usually taken at face value and treated as scientifically proven entities rather than as the contested concepts they actually are (Bentall, 1990; Boyle, 1994, 2002).

Pilgrim and Treacher (1992) suggest that the tendency to work within the medical paradigm is primarily due to the pre-existing dominance of medicine over psychological suffering; a fact which had a significant shaping influence on the new discipline of clinical psychology. Pilgrim (1990) also points out that systematic psychological theorising about 'mental illness' is often biologically orientated "evading sociological and anthropological modes of deviance".

Clinical psychology, like psychiatry, is also primarily focused on the individual (Handy, 1987; Hare-Mustin & Marecek, 1997). As Handy (1987, pp. 165-166) notes,

> [b]oth the formal models of the discipline and the majority of published clinical research utilize a scientist practitioner model which concentrates on explaining and treating individual or family dysfunctions without locating these issues within a broader analysis of organizational or societal contexts.

Handy (1987, p. 166) further points out that this traditional perspective thus conveys three implicit messages.

> Firstly, that the organizational or social levels of analysis and intervention are somehow peripheral to the real work of clinical psychologists which concerns the direct treatment of the personal problems of disturbed individuals. Secondly, that psychological skills are a form of technological expertise which can be acquired through training in the theory and techniques of applied psychology. Thirdly, that the application of these skills is positively valenced and does not involve issues of power, conflict, morality or faith.

It seems, then, that the vast bulk of the literature written primarily for mental health professionals (journal articles, handbooks, diagnostic manuals, etc.) is in line with the central tenets of the DMA; that the aetiology and the course of psychological suffering is located within the psychology and/or the biology of each individual sufferer

and that such suffering can be categorised into discrete disorders which can be diagnosed, and hopefully cured, by mental health professionals. Indeed, as Read and Harré (2001, p. 224) point out

> [s]o strong is the faith in this approach [among mental health professionals] that one study (Rahav, 1987, cited in Read & Harré, 2001, p. 224) defined agreement with 'Mental illness is an illness like any other' as an example of a 'liberal, knowledgeable, benevolent, supportive orientation toward the mentally ill'.

Read and Harré (2001) also note that the belief that psychological suffering is 'mental illness' and that 'mental illness' is akin to physical illness has been central to campaigns designed to raise the public's awareness of such suffering and to reduce the stigma associated with it. As the US Joint Commission on Mental Illness and Health pointed out in 1967 (cited in Read & Harré, 2001)

> The principle of sameness as applied to the mentally sick versus the physically sick . . . has become a cardinal tenet of mental health education.

There are numerous examples of this in material released by governmental and professional organisations on 'mental health' topics in New Zealand and overseas. Such information is vigorously disseminated to the public by both governmental and professional organisations in an attempt to encourage people to conceptualise more and more varieties of suffering as 'mental disorder'.

For example, in 'Learning about mental illness' (Ministry of Health, 1993), a pamphlet distributed by the New Zealand Ministry of Health to educate people about 'mental illness', it was noted that

> [m]ental illness covers the different types and degrees of disorder which affect the mind and lead to changes in emotional moods, behaviour, communication, thinking . . . Like physical illness, mental illness is nothing to be ashamed of and is not someone's fault.

Another New Zealand Ministry of Health pamphlet entitled 'Everyday people and mental illness' (part of an ongoing campaign to destigmatise 'mental illness') states that

> [m]ental illness' is a term that refers to a group of illnesses that affect a person's mind – much the same as 'heart disease' refers to a group of illnesses that affect a person's heart. [The mentally ill] need the same understanding, support and acceptance as people who are physically ill. Mental illness is no different.
>
> (Ministry of Health, 1997)

A pamphlet distributed to the public by the Schizophrenia Fellowship NZ states that "[m]ental illness is a biologically-based medical problem, like any other illness". They go on to note that

> The causes of schizophrenia are not fully understood. Biochemical and genetic factors play a part, and like other complex biological illnesses, there may be environmental factors.

The Schizophrenia Fellowship NZ also notes, in a booklet entitled *About Schizophrenia* (Schizophrenia Fellowship (N.Z.) Inc., 1996, p. 10), that

> In the 1960s and 1970s there were many social theories which claimed that patterns of family interaction were the cause of schizophrenia. There is no evidence to support any of these theories and no one with any knowledge of the subject would refer to them. [13]

The influential National Institute of Mental Health in the United States makes similar statements on its website. For example:

> Schizophrenia, bipolar disorder, depression, autism, and other mental disorders are serious, often life-threatening illnesses for which we need reliable diagnostic tests, new treatments, and effective strategies for prevention.
>
> Thomas R. Insell, Director, NIMH (Insell, 2004)

> The NIMH mission is to reduce the burden of mental illness and behavioral disorders through research on mind, brain, and behavior. This public health mandate demands that we harness powerful scientific tools to achieve better understanding, treatment, and eventually, prevention of these disabling conditions that affect millions of Americans.
>
> Facts about NIMH, posted 9/4/2004,
>
> (National Institute of Mental Health, 2004a)

> Revolutionary scientific advances in neuroscience, molecular biology, genetics, and brain imaging have provided some of the greatest insights into the complex organ that is the seat of thought, memory, and emotion. Thanks to these new tools, the scientific evidence that mental illnesses are *brain disorders* now exists.
>
> About NIMH, 12 July 2003
>
> (National Institute of Mental Health, 2003, my italics)

[13] The surety with which the Fellowship assures its readers that schizophrenia is a biological illness (despite there being little evidence that biological factors play a major causal role in schizophrenia (Bentall, 2004; Breggin, 1991; Valenstein, 1998; Whitfield, 2004), together with the surety with which they dismiss the significance of social factors in the aetiology of schizophrenia (despite a large volume of research suggesting childhood trauma may play a causal role in the problems commonly subsumed under the label 'schizophrenia') (Read, 1997; Whitfield, 2004), betrays an ideological rather than a scientific approach to the suffering with which they are concerned. As Whitfield (2004, p. 173, author's italics) points out over the last forty years "for every *one* study that addressed the trauma-schizophrenia link there have been *forty-six* on genetics and *thirty* on the biochemistry of schizophrenia . . . a remarkable discrepancy that biases all results in favor of the biogenetic theory by a ratio of 74 to 1".

The DMA is also dominant in material aimed at those suffering from specific 'mental disorders'. For example, in its campaign to raise awareness of depression in men, *Real Men, Real Depression* it is declared:

> Depression is a serious but treatable medical condition - a brain disease - that can strike anyone, including men.
>
> *Real men, real depression* public awareness campaign
>
> (National Institute of Mental Health, 2004b)

The American Psychiatric Association, one of the most powerful organisations in the mental health field similarly states on the Public Information section of its webpage that

> Mental illness is an illness that affects or is manifested in a person's brain. It may impact on the way a person thinks, behaves, and interacts with other people. The term "mental illness" actually encompasses numerous psychiatric disorders, and just like illnesses that affect other parts of the body, they can vary in severity. Many people suffering from mental illness may not look as though they are ill or that something is wrong, while others may appear to be confused, agitated, or withdrawn.
>
> It is a myth that mental illness is a weakness or defect in character and that sufferers can get better simply by "pulling themselves up by their bootstraps." *Mental illnesses are real illnesses*--as real as heart disease and cancer--and they require and respond well to treatment.
>
> (American Psychiatric Association, 2004,my italics)

NAMI (National Alliance for the Mentally Ill), an organization which offers support and advocacy for 'consumers', families and friends of people with 'severe mental illnesses', also enthusiastically endorses the DMA account of psychological suffering, particularly its biological version. For example, in describing depression, NAMI (National Alliance on Mental Illness, 2006, author's italics) notes

> Major depression is a serious *medical illness* affecting 9.9 million American adults, or approximately 5 percent of the adult population in a given year. Unlike normal emotional experiences of sadness, loss, or passing mood states, major depression is persistent and can significantly interfere with an individual's thoughts, behavior, mood, activity, and physical health. Among all *medical illnesses*, major depression is the leading cause of disability in the U.S. and many other developed countries.
>
> There is no single cause of major depression. Psychological, biological, and environmental factors may all contribute to its development. Whatever the specific causes of depression, scientific research has firmly established that major depression is a *biological brain disorder*.

The Surgeon General of the United States also endorses an 'illness/disease' understanding of psychological suffering.

> Mental illness is a term rooted in history that refers collectively to all of the diagnosable mental disorders. Mental disorders are characterized by abnormalities in cognition, emotion or mood, or the highest integrative aspects of behavior, such as social interactions or planning of future activities. These mental functions are all mediated by the brain. It is, in fact, a core tenet of modern science that behavior and our subjective mental lives reflect the overall workings of the brain. Thus, symptoms related to behavior or our mental lives clearly reflect variations or abnormalities in brain function.
>
> (U.S. Department of Health and Human Services, 1999)

The above discussion strongly suggests that the conceptualisation of psychological suffering as being due to some kind of individual disorder or dysfunction of the mind (or brain) is central to the majority of mainstream professional discourse about such suffering. Indeed, it seems there are no mainstream mental health organisations or advocacy groups that do not take this position.

It seems then that the neo-Kraepelinians have been very successful in their campaign to establish that 'mental illnesses are not myths'. The notion that mental health professionals are dealing with real entities (i.e., that 'depression' and 'schizophrenia' and 'obsessive-compulsive disorder' are valid scientific constructs) which can be easily identified in the 'real world', now seems essentially unquestioned in the vast majority of mainstream professional discourse.

While many of the quotes I have cited above could be interpreted as embracing both versions of the DMA (the biological/somaticist and or the psychological/ metaphorical) many of them clearly favour the biological version. It has been pointed out by a number of authors (Barrett, 1996; Kemker & Khadivi, 1995; Lipowski, 1989; Luhrman, 2000; Pam, 1995b; Pilgrim, 2002; Pilgrim & Rogers, 1999; Sanua, 1993; Whitfield, 2004; Breggin, 1991; Valenstein, 1998) that the biological version of the DMA is becoming increasingly dominant within psychiatry.

Interestingly, despite the American Psychiatric Association's diagnostic manual the DSM claiming 'theoretical neutrality' (i.e., that it makes no aetiological claims) the Association recently issued a press release (American Psychiatric Association, 2003) that suggested that the organisation did in fact support a more biologically oriented position on 'mental illness'. This statement was in response to "those who would deny that serious mental disorders are real medical conditions that can be diagnosed accurately and treated effectively" (American Psychiatric Association, 2003, p. 3) and noted that

> Research has shown that serious neurobiological disorders such as schizophrenia reveal reproducible abnormalities of brain structure (such as ventricular enlargement) and

> function. Compelling evidence exists that disorders including schizophrenia, bipolar disorder, and autism to name but a few have a strong genetic component[14].

It is perhaps not surprising that the APA is becoming more explicit in its endorsement of a more biological approach to mental illness considering that the architects of the DSM-III were strong advocates of such an approach (Bentall, 2004; Kirk & Kutchins, 1992; Kutchins & Kirk, 1997). Indeed, one of the main aims of Robert Spitzer and his fellow neo-Kraepelinians[15] was to place psychiatry firmly back into the fold of general medicine and, towards that end, to focus psychiatry primarily on the biological aspects of mental illness.

This biological slant is also reflected in psychiatric training (Breggin, 1991; Kemker & Khadivi, 1995; Luhrman, 2000; Reiser, 1988). As American psychiatrist Susan Kemker (Kemker & Khadavi, 1995, p. 242) notes

> throughout most of my residency, I took for granted the medical model of psychopathology. I did not always grasp the fine points of biological research, but I certainly respected it. As far as I knew, biology was the 'science' of psychiatry.

Kemker (Kemker & Khadavi, 1995, p. 246) further notes that

> As a psychiatric resident . . . I would explain that mental illness is caused by a chemical imbalance in the brain. Mental illness resembles diabetes, which involves a chemical imbalance in the body, I would explain. The patient's psychiatric disorder is chronic, I would say, and requires medication every day for the rest of the person's life. I would then assure the patient that if he took the medication, he would probably live a normal life.

Because psychiatry holds a dominant position amongst 'mental health providers' it is perhaps not surprising that there has been an increasing tendency for many other mental health professionals, academics, mental health advocacy groups and governmental agencies to also align themselves with the biological version of the approach (Whitfield, 2004), as is clear from many of the quotes cited above.

This enthusiastic endorsement of the biological version of the DMA occurs despite a startling lack of evidence that psychological suffering is *caused* by faulty biochemistry, anatomy or genes (Boyle, 2002; Breggin, 1991; Joseph, 2003; Ross, 1995a, 1995b; Valenstein, 1998; Whitfield, 2004).

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[14] Again, as Chapter Two will illustrate, this evidence is highly contested.
[15] Neo-Kraepelinian is a term coined by Gerald Klerman to refer to the return to conceptualising psychological suffering as a biologically based illness.

1.2.2. The DMA in the mass media

While the DMA is spread to the public via the publications of governmental and professional organisations it is the mass media (newspapers, magazines, internet, television, radio) that are the main disseminators of this approach (particularly its biological version) to the general public (Busfield, 1986; Horwitz, 2002a; Shorter, 1997). As Horwitz (2002a, p. 117) points out,

> In the contemporary world, the media often work in tandem with medical authorities and pharmaceutical companies to promote the latest fads and fashions in psychiatric diagnosis. Clients often use the knowledge they obtain from the media and from their informal social networks to preselect those professionals they know will be sympathetic to their self-diagnoses. Professionals and sufferers participate in a common culture of illness display disseminated through the mass media.

A perusal of a selection of articles run recently on 'mental health' in *Time*, a popular American magazine aimed at the more 'serious' end of the market, is indicative of the media's approach to psychological suffering. For example, a recent edition of the magazine (November 3, 2003) ran an article purporting to take a critical look at the increasing use of psychiatric drugs on children and young adults. Despite its critical premise, this article took it as a given that the varieties of suffering it described were 'mental disorders', and also that these 'mental disorders' were essentially biochemically based. As the journalist confidently asserted about one young woman:

> [t]he problem, though neither Andrea nor her teacher knew it, was that her adolescent brain was being tossed by the neurochemical storms of generalized anxiety disorder, obsessive-compulsive disorder (OCD) and attention-deficit/hyperactivity disorder (ADHD) – a decidedly lousy trifecta.
>
> (Kluger, 2003. pp. 42-43)

The majority of articles featuring in a special edition of Time (January 20, 2003), focusing on the relationship between mental and physical health, were equally confident that the various 'mental disorders' identified by psychiatry were valid concepts with mainly physiological causation. For example:

> Schizophrenia is the most personally destructive and least understood of all the major mental illnesses . . . The cause is undeniably physical – perhaps the unhappy combination of a genetic predisposition and an infection suffered in the womb.
>
> (Gorman & Cole, 2003, p. 66)

> Scientists have made great strides in sorting out the underlying causes of depression: it is almost certainly a defect of some combination of key genes, plus the right triggering environment . . . But while the disease-depression connection is becoming more and more clear, how to uncouple them is an uncharted process.
>
> (Lemonick, 2003, p. 46)

Even those articles in this feature which were less 'disorder-oriented' such as 'Is there a formula for joy?' (Corliss, 2003) or those which were more critical of the psychiatric approach like 'How we get labelled' (Cloud, 2003) basically accepted the existence of 'mental disorders'. The only article in which the 'mental disorder' approach was openly questioned was a one-page tongue-in-cheek look at the multitude of mental disorders the author could potentially be suffering from (Kirn, 2003). This article was sandwiched between "One family's burden" (Gorman & Cole, 2003) a serious look at the 'major mental illness' schizophrenia and 'Postcards from the brain' (Park, 2003) which declared confidently that with the information provided by new brain scanning technologies "doctors are beginning to understand – at the level of the neuron – how mental illnesses occur" (Park, 2003, p. 70).

This uncritical acceptance of the notion of 'mental disorders' seems to be equally common in the New Zealand media. In an article called 'The Unfriendly Isles', about the difficulties faced by non-European migrants to New Zealand, the journalist noted that

> Many refugees have mental health problems. Overseas research estimates the number at more than 50 percent, "ranging from chronic mental disorders to trauma, distress and a great deal of suffering".
>
> (O'Hare, 2004, p. 18)

The same article also quotes Auckland psychiatrist, Dr Sai Wong, who suggests that

> Caught up in the daily struggle to build a new life . . . refugees often put their mental anguish down to the difficulties of finding a job or separation from family . . . They think pathological depression is just a common variety of unhappiness.
>
> (O'Hare, 2004, p. 18)

Implicit in this quote is the assumption that the kind of suffering we call 'mental disorder' is not 'just suffering', it is pathology. Another example of this assumption occurred on National Radio's Nine to Noon show (10 February, 2003) when the host, Linda Clarke, asked the lawyer of a Sri Lankan girl facing deportation by the New Zealand Government

> Is the child not eating or drinking as some kind of protest or is this the symptom of mental illness?

This question again accepts the idea that the kind of suffering called 'mental illness' is quite different from any other. The young woman could be refusing food and drink as 'a kind of protest', in which case she is in charge of her behaviour and that behaviour can be understood within the 'normal' frame and rendered 'meaningful'. If she is refusing food and drink because she is 'mentally ill', however, her behaviour can no longer be understood within the normal frame and becomes, essentially, meaningless. The 'mental illness' becomes the explanation for the behaviour. The notion that it is the 'mental illness' that causes many kinds of psychological suffering is fundamental to the Dysfunctional Mind Account. As the Schizophrenia Fellowship NZ points out to its readers in a pamphlet entitled *Understanding Mental Illness*[16],

> Mental illness can cause people to behave in unusual ways or to think or feel very differently from other people.

Implicit in such statements is the notion that a behaviour is either 'normal' and thus self-driven and essentially 'rational' (i.e., that the girl could have been refusing food and drink as a protest) or it is 'symptomatic' of a mental illness, and thus beyond the person's control and 'irrational' (in which case the girl could have been refusing food and drink because she was driven to do so by her 'mental illness'). The people responsible for deciding whether behaviours are 'normal', or not, are primarily psychiatrists and clinical psychologists.

It has been suggested by a number of authors that the continual claims by both the media and professional organisations and advocacy groups that more and more forms of psychological suffering are 'illnesses' is leading to what is often referred to as the 'medicalisation', or perhaps more accurately 'psychiatrisation' of more and more aspects of human life (Conrad, 1980, 1992; Conrad & Potter, 2000; Fox, 1994; Horwitz, 2002a; P. Miller, 1986).

Indeed, this is a matter of concern for many of those who embrace the DMA, but who see their position as being compromised by the increasing number of 'normal distresses' which are being drawn into the realm of 'mental disorder (Horwitz, 2002a, 2002b; Shorter, 1997). Many such critics blame psychiatric 'empire building' and drug companies attempting to create bigger markets for their products, and the media's buy-in to these trends. As Shorter points out (1997, p. 290),

> The boundaries of what constitutes depression have been expanded relentlessly outward. Depression as a major psychiatric illness involving bleakness of mood, self-loathing, an inability to experience pleasure, and suicidal thoughts has been familiar for many centuries. The illness has a heavy biological component. Depression in the vocabulary of

[16] This pamphlet was sponsored by Eli Lilly & Company (NZ) Limited. Such alliances between patient advocacy groups and drug companies are very common.

> post-1960s American psychiatry has become tantamount to dysphoria, meaning unhappiness, in combination with loss of appetite and difficulty sleeping. Thus it comes as no surprise that the incidence of depression so defined has been rising and occurring at ever younger ages.

Such critics suggest that this 'psychiatrisation' or 'psychologisation' of normal distress is drawing attention and resources away from 'real mental disorders', which, as Shorter (1997, p. 323) points out, cause "terrible pain and disablement". They are also concerned that it is undermining the disorder-based approach to psychological suffering; if people begin to doubt the credibility of some of these newer 'non-disorders' then they may begin to doubt the credibility of the entire approach.

1.2.3. The DMA in the discourse of the 'mentally ill'

> A medical diagnosis of PND [post-natal depression] took the pressure off me.
>
> (Jeeves, 2004, p. 118)

> Depression has darkened my life for a long time now, and despite my best efforts there has been no escaping it. It has hounded me wherever I've gone, following me halfway around the world and back, like a dark and ominous cloud. I liken it to an eclipse of the sun, taking the light and colour away, and leaving only a world of grey. My treatment and rehabilitation began four years ago at Sunnyside Hospital, where I have been treated as an outpatient, but I have been ill for a lot longer than that.
>
> (McNeil, 1993, p. 13)

> I was diagnosed with bipolar disorder 18 months ago. I kind of always wondered what was different about me. I'd always been quite a hyped up, racy, kind of full-on person, always rushing somewhere or doing something. It wasn't until I looked back recently at some of the comments people have made to me over the past four years in particular that I had any idea that I was different to other people. It was when I was doing two PR papers at Massey, working fulltime, a secretary for two voluntary committees, a wife and a mother that things started to fall apart. Eighteen months ago three police officers and an emergency psychiatric nurse came to my house. I asked them to take their shoes off and they wouldn't and I got mad. I actually assaulted them and was taken kicking and screaming handcuffed by the hands and feet – carried out like a roll of carpet to a police car and taken to the secure psychiatric unit at Wellington Hospital.
>
> (Simmons-Donaldson, 2003, p. 6)

> I've had ADHD for 10 years now. I was diagnosed with it in kindergarten. Truthfully, I don't remember every detail of my life before ADHD, but there are some things I can't help remembering. For example, in kindergarten I was sent to the "time-out chair" about two or three times daily. The reason? I would say things that would hurt the other kids. Why did I say these mean things? Because I'd never think about what I was going to say or the consequences. Another thing I'll never forget is how antsy and talkative I was. Every day after lunch, there was a competition to see whose table was the quietest. Of course, I could never stop talking or moving, so my table was always last.
>
> Andrea (Castro, 2003, p. 50)

> When I was really bad I heard other voices. They were people from my work. It was getting out of control so that's when I had to leave and saw the psychiatrist. She told me then that I had schizophrenia. That was really quite awful, because she had to try to explain it to my father as well.
>
> (Traynor, 1997, p. 172)

> I knew nothing about mental illness. I had long periods of depression, not knowing I was sick. I just blamed myself for being lazy . . . I did some stupid things, I drank my own urine, stripped in public, tried to kill myself. I ran away from home and did crazy things.
>
> (O'Hare, 2004, p. 18)

> During this time my husband began to have affairs with other women. My depression got worse. I began to isolate myself. I was afraid to see people . . . I didn't realise I was suffering from a mental illness. When it became too hard to bear I overdosed on drugs.
>
> (O'Hare, 2004, p. 13)

The quotes cited above are all from first-person accounts of psychological suffering (obtained from media sources and books) in which the suffering is acknowledged by the sufferer to be a 'mental disorder' of some kind. This acceptance of psychological suffering as 'illness' or 'disorder' is actively encouraged by many mental health professionals (Kemker & Khadivi, 1995; Read & Harré, 2001).

The author of the first excerpt cited above was diagnosed with postnatal depression[17], a diagnosis which she claimed "took the pressure off me" (Jeeves, 2004, p. 118) noted that at the time of her 'illness' she was reluctant to take medication but "in hindsight this should not have been my choice as I was too sick to make the right decision" (Jeeves, 2004, p. 118).

The second excerpt is by a journalist who, given the opportunity to write an article about 'depression[18]', decides to "admit to herself and others" that she has a mental illness. She discusses her 'illness' in primarily medical terms; noting that there are

> two types of depression, reactive and endogenous[19]. Reactive depression is caused by an external force such as grief – the loss of a loved one, redundancy, divorce, surgery, or moving house. Endogenous depression is brought about by a chemical imbalance in the

[17] Post Natal Depression is not designated as a separate 'disorder' in the DSM-IV-TR (American Psychiatric Association, 2000). If a woman becomes depressed within 4 weeks of giving birth she is diagnosed as suffering from a mood disorder (there a number of these and her diagnosis would depend on her 'symptoms'). The specifier 'With Postpartum Onset' is then added to the original 'disorder'. So, for e.g., the woman could be diagnosed as suffering from 'Mixed Episode of Major Depressive Disorder with Postpartum Onset'.

[18] See Chapter Six for a description of 'major depressive disorder'.

[19] This distinction is not made by the DSM-IV firstly because the endogenous/exogenous distinction is highly contentious even amongst those who support the DMA (Gotlib & Hammen, 1992) and also because the distinctions carry implications about etiology, which the DSM eschews in its attempts to be 'atheoretical'.

> brain. To the sufferer there is no apparent reason for it. My depression is thought to be endogenous.
>
> (McNeil, 1993, p. 13)

She acknowledges that being told her depression is 'endogenous' makes it "harder to deal with, and more difficult to accept". Nevertheless she does accept her diagnosis and the "life sentence of swallowing pills" that it entails (McNeil, 1993, p. 13).

The author of the third excerpt, diagnosed with bipolar disorder[20], was also quite accepting of her diagnosis, noting that it explained why she had always been different from other people. She also points out that she suffered "a minor brush with depression not long after my father died" and "suffered from postnatal psychosis" after the birth of her two daughters. She suggests her mental illness may have something to do with her "designer genes".

The author of the fourth excerpt is an American teenager who has "had ADHD[21] for 10 years now. I was diagnosed with it in kindergarten" (Castro, 2003, p. 50). After trying Ritalin "which was not very good for me" (Castro, 2003, p. 50) she now takes Adderall. She states that her medicine "lets me perform to my full ability" (Castro, 2003, p. 50). Nevertheless she notes that her personality has changed because of it and she has "lost a whole bunch of friends", which gets her "depressed at times" (Castro, 2003, p. 50). She also notes that her relationship with her family has changed.

> When I am off my medication, I am hysterically funny with my parents and a lot more imaginative in playing with my younger sister and brother. But I also have a shorter temper, which leads to conflicts with my sister. We make each other cry. So my condition and treatment have definitely affected my family, for good and bad.

The person cited in the fifth excerpt migrated to Australia when she was five and felt ostracised and different in her new country. Her mother, with whom she still lives, hit her and was "really bad with her nerves" and she was frightened of her father who was bad tempered and distant. She started hearing voices at nineteen and a psychiatrist put her on Trofrinil (antidepressant) and then, after learning that she was hearing voices, put her onto Largactil (anti-psychotic). This woman notes that while "perhaps you can never completely recover [from schizophrenia[22]] . . . if you can accept your illness, you're on your way to recovery" (Traynor, 1997, p. 179).

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[20] 'Bipolar disorder' is a 'mood disorder' characterised by episodes of 'mania' (extremely elevated mood) alternating with episodes of 'major depression' (American Psychiatric Association, 2000).
[21] 'Attention Deficit/Hyperactivity Disorder', the essential feature of which is a "persistent pattern of inattention and/or hyperactivity-impulsivity that is more frequent and severe than is typically observed in individuals at a comparable level of development" (American Psychiatric Association, 2000).
[22] See Chapter Six for a description 'schizophrenia'.

The author of the sixth extract migrated to New Zealand from Asia with her husband and daughter. Her and her husband attempted to start two businesses, both of which failed causing her to "crack" with the stress. She, like all the others quoted above, was accepting of her diagnosis (of bipolar disorder) and after recovery she now helps run Bo Ai She, a self-support group for other Asian women recovering from mental illness.

The author of the sixth extract is also a migrant to New Zealand. She still misses her family and her homeland and "unable to speak English well or engage with the New Zealand way of life, she found her life beginning to unravel" (O'Hare, 2004, p. 13). She has tried to kill herself eight times. She now realises she is "suffering from a mental illness" (depression). There is no indication in the article of what treatment she received or whether she is recovering.

Perhaps not surprisingly, given the dissemination of the DMA to the public via the media, either directly (through interviews with mental health professionals/experts) or indirectly (through journalists' assumptions that the MDA is scientific fact), accounts such as these are becoming increasingly common in public discourse about such suffering (Horwitz, 2002a). Of course these accounts in turn, because of their public nature, also play a part in the further dissemination of the DMA.

Such accounts suggest a general acceptance, indeed even a willingness, on the part of those who are experiencing certain kinds of distress to attribute that distress to some sort of disorder or dysfunction inside themselves. As the above authors were all concerned to point out, their suffering had been officially diagnosed as 'mental disorder'. They were not mad, or malingering, neurotic, or imagining things; they were ill. It is important to note, of course, that the prevalence of such accounts in the media does not necessarily reflect a general acceptance of a diagnosis of 'mental illness' amongst all those who suffer psychologically; rather, it may be that those who do not accept that they are 'mentally ill' are less likely candidates for media interest. If this is so, of course, it suggests a bias towards an illness or disorder based conceptualisation of psychological suffering on the part of the media.

1.2.4. The DMA in lay-people's conceptualisations of psychological suffering

As Whittle (1996, p. 259) points out, by the early 1970s

> it had been concluded that the lay ability to recognise mental disorder had increased at least as far as serious mental disorder was concerned and that mental illness was

> increasingly regarded as an illness like any other illness which was the message behind much of the psychiatric educational efforts in the '50s and '60s.

Whittle (1996) goes on to note that there had been a continuing trend to construe mental disorder in this way ever since. This is supported by the Surgeon General's Report (U.S. Department of Health and Human Services, 1999) in which it was noted

> By 1996, a modern survey revealed that Americans had achieved greater scientific understanding of mental illness . . . The public learned to define mental illness and to distinguish it from ordinary worry and unhappiness. It expanded its definition of mental illness to encompass anxiety, depression, and other mental disorders. The public attributed mental illness to a mix of biological abnormalities and vulnerabilities to social and psychological stress.

Interestingly, however, a number of studies suggest that despite the public's willingness to accept the idea that certain forms of psychological suffering are 'illness', it seems that they considerably less willing to accept what Svensson (1995) would refer to as the Somaticist Medical Model account (where psychological suffering is seen as a biological illness). Research has suggested that the predominant lay view seems to reflect a more Metaphorical Medical Model account (where the notion of 'illness' is used metaphorically, allowing for causal theories beyond the biological) (Angermeyer, Matschinger, & Holzinger, 1998; Furnham & Bower, 1992; Furnham & Kuyken, 1991; Furnham & Rees, 1988; Jorm et al., 1997; Kemker & Khadivi, 1995; Kuyken, Brewin, Power, & Furnham, 1992)

There are some exceptions to this general support for more psychosocial theories, however. For example, Angermeyer, Matschinger and Hozinger (1998) found that relatives of schizophrenics held more 'biological/constitutional' beliefs than other lay people. The authors suggested that this was because of "greater exposure to the knowledge of psychiatric experts and their having to deal with their own feelings of guilt". Kuyken, Brewin, Power & Furnham (1992) also found that depressed patients tended to endorse biological explanations more than clinical psychologists did, perhaps for similar reasons. Indeed, as Drew (1996) found in her analysis of the discourse of depressed patients one of their major aims was to deflect blame for their problems away from themselves and towards other sources, with the 'illness discourse' (i.e., biologically based) being one effective means of achieving this.

1.3. CONCLUSION

In this chapter it has been suggested that the Dysfunctional Mind Account is central to most public discourse (professional and lay) about certain kinds of psychological suffering, particularly that which is long-lasting and/or intense. Such suffering is widely accepted to be the manifestation of some kind of 'mental illness' or 'mental disorder' and is generally located within the mind (or brain) of the sufferer. The individual person is also seen as the main target of treatment and intervention[23], with the individual's biology often being the primary target (Pilgrim & Rogers, 1999; Sanua, 1993; Whitfield, 2004). This conceptualisation makes it considerably less likely that such suffering will be seen as understandable response to life and increasingly likely that it will be viewed, by professionals, sufferers and laypeople alike, as 'ununderstandable[24]'.

As Horwitz (2000, p. 4) points out

> A huge cultural transformation in the construction of mental illness has occurred in a relatively short time. The broad array of mental illnesses at the beginning of the twenty-first century has little resemblance to older stereotypes of madness that persisted throughout most of human history . . . The extensive use of disease categories for a wide variety of human behaviours is unique in human history; most of the many mental illnesses that are now taken for granted as objective natural entities are recent creations.

Such widespread acceptance of the DMA, however, does not necessarily mean that conceptualising psychological suffering as 'disorder' or 'dysfunction' is well founded theoretically, and nor does it mean that it is effective in a practical sense. In the following chapter it will be argued that the conceptualisation of psychological suffering referred to in this thesis as the Dysfunctional Mind Account is not adequate to the task of explaining, alleviating (in the long-term), or preventing psychological suffering.

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[23] This is not to deny that many 'treatments', particularly those of a 'psychological' kind, attempt to intervene at a relationship or family group level. Such approaches, however, are less common, particularly for the so-called 'major mental disorders', than more individually based treatments (Pilgrim & Rogers, 1999).

[24] In *General Psychopathology*, Jaspers (1913, 1963, cited in Sass, 2002) examines the relationship between understanding and disorder, noting that understanding sometimes reaches the point where despite every effort to empathise with a person, their experiences or behaviour are 'ununderstandable' – 'one psychic event follows another quite incomprehensibly; it seems to follow arbitrarily rather than emerge' (Jaspers, cited in Szmukler, 2004). At this point, argued Jaspers (1913, 1963, cited in Sass, 2002), we encounter signs of a 'mental illness', and some sort of 'dysfunction' of 'mind' or brain must be occurring.

CHAPTER TWO

PROBLEMS WITH THE DYSFUNCTIONAL MIND ACCOUNT

2.1. INTRODUCTION

Despite the general acceptance of the DMA amongst most mainstream mental health professionals and many lay-people this approach to psychological suffering has long been the subject of intense criticism, not only from academic disciplines such as psychology, sociology, philosophy and anthropology but also from non-medical mental health professionals, disaffected 'consumers' of mental health services and even from within psychiatry itself. Such criticisms began in earnest during the 1960's and 1970's and, as Svensson (1995, p. 2) notes, were part of a "broad and multi-faceted critique of many established ideas, institutional practices and taken-for-granted ways of thinking about and dealing with human affairs".

Many of these early critics are grouped together as the 'anti-psychiatrists', though as Svensson (1995, p. 12) points out "they were actually a very heterogeneous group, differing widely as to ideological platform and motivation". Thomas Szasz (e.g., Szasz, 1960, 1970, 1974, 1993) and R.D. Laing (e.g., Laing, 1967) are perhaps the best known of the 'anti-psychiatrists'. Szasz focused directly on questioning the validity of the concept of 'mental illness' to make his point that psychiatry was an instrument of social control rather than a genuine medical speciality dealing with genuine medical illnesses. R.D. Laing claimed that those problems called 'mental disorders', and in particular schizophrenia, were actually a normal or expected reaction to pathological situations.

Other early critics, sometimes also characterised as 'anti-psychiatrists'[1], such as Thomas Scheff (e.g., Scheff, 1986, 1999) and Erving Goffman (e.g., Goffman, 1962) argued that psychiatry functioned as a politically repressive force, and that 'mental disorders', rather than being 'real-world' entities, were primarily instruments of social

[1] See, for example, psychiatrist-historian Shorter's discussion of the 'anti-psychiatry movement' that includes Foucault, Goffman and Scheff (1997, pp. 274-276).

and ideological control. This theme has also been explored in a number of 'historiographies' of psychiatry by authors such as Michel Foucault (1965), Robert Castel, Francois Castel & Anne Lovell (1982), Klaus Doerner (1981) and Andrew Scull (1979; 1993).

This criticism sparked a spirited response from the psychiatric profession, who provided counter-attacks in books such as *Psychiatry in dissent* by Anthony Clare (1976), *Reasoning about Madness* by John Wing (1978) and *The Reality of Mental Illness* by Martin Roth and Jerome Kroll (1986). Indeed, as has been noted in Chapter One, the development of the 'biopsychosocial' approach to 'mental illness' was a direct result of criticism that psychiatry was overly biological and reductionist in its approach to psychological suffering.

The critiques directed against psychiatry and the DMA were also, at least in part, responsible for the change of direction taken by the Third Edition of the American Psychiatric Association's (American Psychiatric Association, 1980) *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III). As already discussed in Chapter One this version of the Manual abandoned the psychodynamically inspired approach which informed the first two manuals and focused on delivering a nosological system which was more "empirically based and scientifically rigorous" (Millon, 1986).

The sustained criticism of the conceptualisation of psychological suffering as 'mental illness' (referred to in the DSM as 'mental disorder') also stimulated a number of publications attempting to defend the validity and usefulness of the concept (see for example Boorse, 1981, Macklin, 1981, Margolis, 1980, all cited in Svensson, 1995; Wakefield, 1992a, 1992b). The necessity of defending the concept against critics also played a role in the decision of the Task Force who oversaw the development of the DSM-III to provide a definition of 'mental disorder' in the Introduction to the Manual (Millon, 1986). This definition, and the difficulties encountered in defending it, will be discussed below.

Despite psychiatry's claims that the debate is now over (Klerman, 1984, cited in Kirk & Kutchins, 1992); that "mental illness does indeed exist" (O'Connell, 1988, p. 1025), and that psychiatry is a legitimate and necessary enterprise (Clare, 1976; Shorter, 1997) the criticism has continued. Much of this more recent criticism has been aimed at the political-ideological place of psychiatry in modern Western societies. Some examples of such critiques include those of Andy Treacher and Geoff Baruch (Treacher & Baruch, 1980), Joel Kovel (1980), Peter Miller (1986), Nikolas Rose (1986), Joan Busfield (1986), and Stuart Kirk and Herb Kutchins (1992; Kutchins & Kirk, 1997). There have also been

several feminist critiques of psychiatry, for example Elaine Showalter (1987), Phyllis Chessler (1989) and Jane Ussher (1991).

Some recent critics have also focused their attention specifically on the biological version of the DMA, for example Alvin Pam (1995), Colin Ross (1995a; 1995b), Ellen Borges (1995), Elliot Valenstein (1998), Peter Breggin (1991) and Charles Whitfield (2004). Other critics have taken issue with the DMA from within a cross-cultural or anthropological perspective, for example John Carr and Peter Vitaliano (1985), Gananath Obeyesekere (1985), Leo Kirmayer (1994a; Kirmayer, 1994b), Charles Keyes (1985), and Rob Barrett (1996).

While many of the more recent critiques have been directed at the entire enterprise of psychiatry; its theoretical foundations, its institutions, its treatment technologies, and its ideological-political position in Western societies there has, nevertheless, been a continuing focus on questioning the validity of the concept 'mental illness'. Indeed, Svensson (1995, p. 7) suggests that the concept of mental illness is "the pivot around which the entire debate [about the validity and usefulness of the psychiatric approach] rotates".

Some examples of recent critiques directed specifically at the concept of 'mental illness' include Tommy Svensson (1995), David Ingleby[2] (1980), Edwin Wallace, Jennifer Radden and John Sadler (1997), Allan Horwitz[3] (2002). Many of these more conceptually based critiques have focused their attention specifically on the validity of certain 'disorders', examples being Richard Bentall (1990) and Mary Boyle (Boyle, 1990; 1994; 1996; 2002)(schizophrenia[4]), and David Pilgrim and Richard Bentall (1999) (depression), an exercise which inevitably raises questions about the validity of the wider concept of 'mental illness'.

It is this conceptualisation of psychological suffering as illness, disorder or disease, and its consequent placement within a medico-scientific framework, that will be the focus of critical discussion in Section 2.2 of this chapter[5]. If this conceptualisation

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[2] Ingleby's (1980) critique also highlights the political and values implications of the 'positivist science paradigm' within which the concept of 'mental illness' is justified and within which psychiatry works. Indeed, most of the critics I cite above touch on both theoretical and political-ideological aspects of psychiatry, I have listed them according to their main focus.

[3] Horwitz (2000), while criticising what he calls 'diagnostic psychiatry's' over-zealous attempts to label every human problem 'mental disorder' does believe that there are 'real' mental disorders. This does not, however, negate the importance of his critique, which focuses on exposing the culturally constructed nature of most 'mental disorders'.

[4] Schizophrenia has been singled out for particularly intensive criticism for its "weak diagnostic accuracy, uncertain aetiology and dustbin-like character" (Miller, 1980, p. 23), starting with the work of R.D. Laing in the 1960s.

[5] It should be noted that underlying and informing all of the problems with the DMA discussed in this chapter is a more fundamental problem relating to how the concept of 'mind' is understood. The conceptualisation of psychological suffering as 'mental disorder' is only possible because of the reification of

cannot be defended then serious doubts are raised concerning the validity and usefulness of the entire Dysfunctional Mind Account of psychological suffering.

It will be argued by supporters of the DMA, however, that what really matters, conceptual difficulties notwithstanding, is the practical utility of the DMA. Thus it is to the DMA's effectiveness at generating strategies for the alleviation and prevention of psychological suffering to which attention will be turned in Section 2.4.

2.2. PSYCHOLOGICAL SUFFERING AS 'MENTAL DISORDER': DEFENDING THE INDEFENSIBLE

> Insanity is, after all, only a disease like other diseases . . . a mind deranged can be ministered to no less effectively than a body deranged . . . The problem of insanity is essentially a public health problem to be dealt with on modern public health lines.
>
> (Royal Commission on Lunacy and Mental Disorder, 1926, cited in N. Rose, 1986)

Underlying the arguments put forward by all but the most determined somaticists to justify conceptualising psychological suffering as 'mental disorder' is the notion that certain kinds of psychological suffering can be usefully conceptualised as analogous to physical disorder. If belief in this analogy did not exist it would make no sense to call certain types of psychological suffering 'mental disorder' or 'mental illness', nor would there be a mandate to deal with such suffering within a medico-scientific framework. Thus, it is of particular importance for psychiatry and allied mental health professionals to defend the conceptualisation of psychological suffering as 'illness' or 'disorder'.

In this section I will discuss some of the efforts to define and defend the general concept of 'mental disorder', an exercise which highlights the considerable difficulties involved in this enterprise and brings into sharp focus the major problems involved in conceptualising psychological suffering as 'mental disorder'.

While debates about the meaning of 'illness' and 'disease' do take place in the area of general medicine they tend to be of primarily academic interest; few medical professionals (researchers or practitioners) expend much concern over whether the

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those aspects of human experience seen as 'psychological' or 'mental' (e.g., thoughts, feelings, perceptions, dreams, etc.) into an entity we call 'mind'. Once this entity is created it is possible to talk about things going wrong with this 'mind'. The issues raised by this reification will be discussed in Section II of this thesis.

problems they are dealing with are 'real diseases'. Nor do they question the appropriateness of dealing with these problems within a medical framework[6]. For mental health practitioners and researchers, however, defining and defending the concept of 'mental disorder', and justifying its inclusion within a medico-scientific framework, is considerably more challenging, particularly for those who are not determinedly somaticist.

As Fulford (2001, p. 80) points out

> It is with mental disorder, not physical disorder, that the most acute conceptual difficulties in clinical work and research in medicine arise.

This, in and of itself, suggests that conceptualising psychological suffering as 'mental disorder' or 'mental illness' is quite different, and considerably more problematic, than conceptualising physical suffering as 'disease' or 'illness'. Nevertheless, efforts to do so, and to justify doing so, have been particularly strenuous in the last four decades.

The criticisms of the 'anti-psychiatrists' during the 1960s and 1970s stimulated the first wave of attempts to 'nail down' what 'mental illness' really was (e.g., Clare, 1976; Kendell, 1975). This led to an attempt to provide a definition of this highly contested concept in the DSM-III (American Psychiatric Association, 1980), which stimulated, according to Sadler (1996, p. 220), a "renewed if ambivalent, interest in the definition of mental disorder".

Attempts to define 'mental disorder'/'mental illness' tend to cluster around several major themes, with many theorists straddling more than one of these. These themes include:

1) Mental disorder is statistical deviation from the norm (e.g., Kendell, 1975; Taylor, 1971; Scadding, 1967, cited in Wakefield, 1992b)
2) Mental disorder is essentially a value judgement reflecting a deviation from some alternative experiences/behaviours which are considered to be more desirable (e.g., Sedgwick, 1982, cited in Wakefield, 1992b)
3) Mental disorder is biologically disadvantageous (e.g., Boorse, 1976; Kendell, 1975)
4) Mental disorder is what mental health professionals treat (e.g., Taylor, 1976)

[6] This is not to say, however, that there is no debate about the traditional medical approach to physical problems (see, for a discussion of this, Busfield, 1986).

The various attempts at defining mental disorder outlined above have been criticised by a number of authors, including the above-mentioned authors critiquing each others work[7]. Wakefield (1992b, p. 374) provides a useful summary of the various problems inherent in each of these attempts to define 'mental disorder' and concludes that

> Despite a vast literature spanning philosophy, psychology, psychiatry, and medicine devoted to the concept of mental disorder, there currently exists no widely accepted analysis that adequately explains even generally agreed upon, uncontroversial judgements about which conditions are disorders.

I will now look at two major attempts to remedy this situation; the definition provided by the DSM-III (and repeated in subsequent versions of the Manual) and the 'harmful dysfunction analysis' of disorder presented by Jerome Wakefield (Wakefield, 1992a, 1992b, 1996, 1997a, 1997b, 1999a, 1999b, 2002).

2.2.1 DSM-III definition of 'mental disorder'

The attempt to formally define 'mental disorder' within the DSM-III has been particularly contentious because of the influence wielded by the Manual on research and practice in the mental health field (see Caplan, 1995; Follette & Houts, 1996; Wakefield, 1992a). Any definition of 'mental disorder' endorsed by the DSM could not fail to exert a major influence on how psychological suffering was subsequently conceptualised, and dealt with, by mental health researchers and practitioners, as was outlined in Chapter One.

The first attempt at defining 'mental disorder' for the purposes of the DSM was as follows

> A medical disorder is a relatively distinct condition resulting from an organismic dysfunction which in its fully developed or extreme form is directly and intrinsically associated with distress, disability, or certain other types of disadvantage. The disadvantage may be of a physical, perceptual, sexual, or interpersonal nature. Implicitly there is a call for action on the part of the person who has the condition, the medical or its allied professions, and society. A mental disorder is a medical disorder whose manifestations are primarily signs or symptoms of a psychological (behavioural nature), or if physical, can be understood only by using psychological concepts
>
> (Spitzer & Endicott, 1978)

This definition is metaphorist (see Chapter One for a discussion of metaphorist and somaticist versions of the DMA) in that it requires acceptance of the notion that a 'mental disorder' is the same as physical disorder, except that in the case of the mental

[7] Wakefield criticises all of them, Kendell criticises Taylor, and vice versa.

disorder the signs and symptoms (and quite possibly the causes) are of a psychological rather than a physical nature. As Follette and Houts (Follette & Houts, 1996, p. 1124) point out, however, despite its metaphorist leanings this definition "raised the hackles of psychologists" because of its open declaration that 'mental disorders' were medical problems; the implication being that they were primarily the responsibility of medically trained professionals. Eventually, after considerable debate and mooted legal action, the American Psychiatric Association agreed to drop any references to mental disorders being medical disorders from the final draft of the DSM-III.

The definition that finally appeared in the DSM-III (American Psychiatric Association, 1980) is as follows:

> In DSM-III, each of the mental disorders is conceptualized as a clinically significant behavioural or psychological syndrome or pattern that occurs in a person and that is associated with present distress (e.g., painful symptom) or disability (i.e., impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom. In addition, this syndrome or pattern must not be merely an expectable and culturally sanctioned response to a particular event, for example, the death of a loved one. Whatever its original cause, it must currently be considered a manifestation of a behavioral, psychological, or biological dysfunction in the individual. Neither deviant behavior (e.g., political, religious, or sexual) nor conflicts that are primarily between the person and society are mental disorders unless the deviance or conflict is a symptom of a dysfunction in the person.

This definition has remained essentially the same through subsequent editions and revisions of the Manual (American Psychiatric Association, 1987, 1994, 2000), despite the criticism directed at it from a wide variety of sources since it was first suggested. The only change is the substitution of the word 'person' in the earlier DSMs with the word 'individual' in the DSM-IV and DSM-IV-TR definitions.

As Follette and Houts (1996, p. 1122) note, while there was now no explicit statement that the medical model was the organizing principle for the DSM, the "underlying ontologies of a weakly stated medical model are easily deducible from [the content of the Manuals]". The 'medical model' implicit in the DSM is primarily metaphorist in character, although it allows for the possibility that "biological entities" (American Psychiatric Association, 1980) may play some part in the etiology of certain 'mental disorders'[8].

The DSM definition of 'mental disorder' has been criticised by a number of authors (e.g., Boyle, 2002; Caplan, 1991, 1995; Follette & Houts, 1996; Pantony & Caplan, 1991;

[8] Though not overtly specified in the DSM-III the intention of those who developed this Manual was to re-medicalise psychiatry (see, in support of this point, the discussion of the 'Kraepelinian Manifesto' Chapter One, Section 1.2.1).

Sadler & Agich, 1996; Wakefield, 1992a; Wallace et al., 1997) on numerous counts, including:

1. The vague use of value-laden terms such as 'clinically significant', 'present distress', 'important', 'impairment', 'freedom', and 'expectable' (Caplan, 1995; Wallace et al., 1997). As Caplan (1995, p. 55) points out, the use of such terms without defining them more precisely leaves "enormous scope for subjectivity and bias".

2. The failure to distinguish between 'behavioural' and 'psychological' or to clearly define what either term actually means within the context of the definition (Wallace et. al., 1997).

3. The failure to define the term 'dysfunction' (Wakefield, 1992a; Wallace et al., 1997). As Wakefield (1992a, p. 235) points out "there is a serious problem with defining disorder directly in terms of dysfunction, if no analysis of dysfunction in simpler terms is provided". Wakefield (1992a, p. 235) goes on to note that "the two concepts are so close in meaning that such a definition does not substantially advance understanding".

4. The failure to clarify the ontological relationship between "a person ('the disordered') and his or her 'disorder'" and the meaning of saying that a 'disorder' occurs 'in' a person (Wallace et al., 1997, p. 70).

In relation to this last point, Wallace et al. (1997, p. 70) note that

> it would seem that the only way we could localize 'mental disorders' (*i.e.*, patterns of experience and behavior) *in* persons is to reconceive persons purely organismically and neurobiologically (*i.e.*, nonphenomenologically and nonsymbolically, with psychosocial and interpersonal perspectives and etiological models discarded altogether). Otherwise . . . we are faced with the products of complex (*biopyschosocial*) originating and sustaining *multicausality*; and 'inner' and 'outer' become at best metaphors for 'private', subjective and 'public,' objective or intersubjective . . . '*In* the individual' would then refer to personal tendencies or dispositions manifested in specifiable situations, circumstances, or environments – i.e., in relational configurations.

It should be noted that this point applies not only to the DSM definition of 'mental disorder' but to all attempts to define the concept, and indeed to all approaches to psychological suffering which seek to define such suffering as illness or disorder. In raising this point Wallace et al. (1997) are highlighting fundamental questions about the

nature of 'mind' and its relationship to the body, questions which are rarely addressed in mainstream psychiatric or clinical psychology literature[9].

2.2.2. Wakefield's 'harmful dysfunction' analysis

One of the most prolific, influential and widely cited critics of the DSMs definition of 'mental disorder' is Jerome Wakefield (1992a; 1992b; 1997a; 1997b; 2002). Wakefield's attempt to redefine 'mental disorder' as 'harmful dysfunction' has been utilised by several authors to determine the validity of a number of 'mental disorders' (see for e.g., Richters & Cichetti, 1993).

Wakefield's account is particularly useful in the context of a discussion of the limitations of the Dysfunctional Mind Account because his criticisms of the DSM definition of 'mental disorder' (and of the whole DSM classification system) are of a very fundamental nature. Indeed, Wakefield (1997a) suggests that in the case of many diagnostic categories the DSM is incapable of distinguishing between 'disorder' and 'non-disorder'.

Such criticisms raise serious questions about not just the DSM, but also about its conceptual underpinnings; the notion that certain forms of psychological suffering are 'mental disorders'. Wakefield's critique is all the more compelling because he is not a radical; he is essentially in support of the DMA, and he is in support of a categorical taxonomy like that presented in the DSM for listing the disorders he firmly contends exist.

Wakefield is fully aware of the implications of the difficulties faced by the DSM and sets out to provide a 'treatment' for its 'disorder' in the form of his own 'harmful dysfunction analysis'; one of the most concerted (he has written numerous articles on the subject over more than a decade) and rigorous attempts to place 'mental disorder' on a firm conceptual footing attempted to date. As such it provides a vivid illustration of just how difficult it is to define and defend the concept, particularly within a primarily metaphorist framework. It is also representative, in many respects, of the assumptions underlying all Dysfunctional Mind Accounts of 'mental disorder'; so the problems associated with Wakefield's account are similarly associated with most such accounts.

[9] Indeed, in subsequent chapters it will be argued that it is to these questions which attention needs to be urgently turned if we are to reach any clearer understanding of the kinds of psychological suffering currently conceptualised as 'mental disorders'.

Wakefield does not disagree with the DSM definition's basic premise that "mental disorders . . . are distresses or disabilities (or other harms) resulting from internal dysfunctions" (Wakefield, 1997, p. 635). Indeed, Wakefield's stated goal is not to overthrow the DSMs definition, but to refine it so that it is capable of allowing "a coherent and valid distinction to be drawn between clear cases of mental disorder and nondisorder that is consistent with the use of disorder in the broader medical sciences" (Wakefield, 1997a, p. 635).

As Lilienfeld and Marino (1995, p. 411) point out

> Whereas most attempts to define disorder are predicated on either value or scientific criteria, Wakefield proposed that the proper analysis of disorder incorporates both value and scientific criteria. Specifically he argued that disorder is best conceptualized as 'harmful dysfunction' whereby 'harm' is a societal judgment regarding the undesirability of a condition (i.e., the value component), and 'dysfunction' is a 'failure of a mechanism in the person to perform a natural function . . . (i.e., the scientific component).

Wakefield suggests that this dysfunction requirement is in line with the "basic intuition underlying judgements of disorder . . . that something has gone wrong with some part of the organism" [10] (Wakefield, 2002).

Neither requirement, for the presence of 'harm', or the presence of 'dysfunction', differs markedly from DSM's definition of 'mental disorder', which also incorporates a harm requirement and a dysfunction requirement. Where Wakefield differs from the DSM is that he makes an effort to provide an analysis of what the internal dysfunction aspect of a 'mental disorder' would actually comprise and how it would be recognised. Wakefield's ultimate aim is to provide a rigorous enough analysis of the dysfunction aspect of 'mental disorders', to allow a dysfunction requirement to be incorporated into the diagnostic criteria in some way (see, for e.g., Wakefield, 1997a).

Wakefield (1992b) begins his analysis of 'dysfunction' by noting that the 'failures of function' implied by the term 'dysfunction' are failures of what he refers to as 'natural functions'. He illustrates what 'natural functions' are by showing how one would go about distinguishing the natural functions of bodily organs (e.g., hearts, lungs, etc) from their other 'effects', giving as his example the heart, which "has the effects of pumping the blood and making a sound in the chest, but only pumping blood is the *natural function*" (Wakefield, 1992b, p. 382).

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[10] It is this notion, that psychological suffering represents a dysfunction in the individual, which this thesis seeks to challenge. This notion not only profoundly affects how such suffering is viewed, treated and experienced, it also means that it is the individual, and what is going on 'inside' them, either metaphorically or literally, who becomes the focus of enquiry in seeking to understand such suffering.

Wakefield (1992) goes on to note that functional explanations can be "plausible and very useful even when little is known about the actual nature of a mechanism" (p. 382) and suggests that

> with natural mechanisms, as with artifacts, the benefits that they provide are so remarkable and depend on such intricate and harmonious interactions that it is often reasonable to infer that the benefit is not accidental. In such cases, if no alternative explanations exist, it is reasonable to infer that the artifact exists because it has these effects. For example, it cannot be merely a happy accident that the eyes enable us to see, the legs enable us to walk . . . The eyes therefore must exist in part because they enable us to see, that is, the fact that the eyes provide sight must somehow enter into the explanation of why we have eyes.
>
> (Wakefield, 1992b, pp. 382-383)

The usefulness of functional explanations, even applied to mechanisms about which little is known, leads Wakefield (1992b, p. 383) to the main point of his argument; that such an analysis "applies equally well to the natural functions of mental mechanisms[11] and thus forms a common basis for the attribution of physical and mental disorder". Wakefield (1992b, p. 383) suggests that

> [l]ike artifacts and organs, mental mechanisms such as cognitive, linguistic, perceptual, affective, and motivational mechanisms, have such strikingly beneficial effects and depend on such complex and harmonious interactions that the effects cannot be entirely accidental.

The application of such functional explanations to 'mental' phenomena yield, according to Wakefield (1992b, p. 383), "ascriptions of dysfunctions when respective mechanisms fail to perform their functions".

Wakefield (1992b) then provides his analysis of 'dysfunction' with what he refers to as "some theoretical substance" (1992b, p. 383) by linking it to evolutionary biology. As Wakefield (1992b, p. 383) explains:

> Today evolutionary theory provides a better explanation [than other competing explanations] of how a mechanism's effects can explain the mechanism's presence and structure. In brief, those mechanisms that happened to have effects on past organisms that contributed to the organisms' reproductive success over enough generations increased in frequency and hence were 'naturally selected' and exist in today's organisms . . . Because natural selection is the only known means by which an effect can explain a naturally occurring mechanism that provides it, evolutionary explanations presumably underlie all correct ascriptions of natural functions. Consequently, an evolutionary approach to personality and mental functioning is central to an understanding of psychopathology.

For Wakefield (1992b, p. 383) this linking of the concept of 'dysfunction' with evolutionary biology means that "[d]ysfunction is thus a purely factual scientific concept", although he does concede that "discovering what in fact is natural or

[11] Wakefield seems to take the existence of these 'mental mechanisms' as a given and makes no real attempts to define what they are or defend their existence (see Boyle, 2002; Sadler & Agich, 1996).

dysfunctional (and thus what is disordered) may be extraordinarily difficult" (Wakefield, 1992b). While Wakefield seems unconcerned about the implications of this, placing his faith in future scientific progress to clarify matters, such 'difficulties' point to fundamental problems with his definition of 'mental disorder', and with the entire enterprise of attempting to conceptualise psychological suffering as such.

As Wakefield (1997a, p. 647) points out, assumptions and

> presuppositions, however inchoate, about underlying mechanisms and their functional programming underlie every disorder attribution, and one benefit of the harmful dysfunction analysis is that it encourages us to start being more explicit in formulating, evaluating and improving these assumptions.

One of the most striking aspects of Wakefield's analysis is that it does make so explicit one of the fundamental assumptions underpinning the concept of 'mental disorder', the assumption of the existence of an 'internal dysfunction'[12]. Wakefield's efforts to define, 'operationalise' and provide 'scientific' justification for the existence of such 'dysfunctions' expose difficulties not just with his own analysis but with the entire enterprise of attempting to validate the concept of 'mental disorder' and attempting to apply that concept to psychological suffering.

Critics of Wakefield's attempt to define 'mental disorder' have highlighted a number of problems with his analysis. Because Wakefield's 'harmful dysfunction analysis' is really no more than a sophisticated attempt to justify present mainstream notions of what a 'mental disorder' is, it is useful to look at some of the key criticisms which have been directed at it because they apply to most mainstream accounts of psychological suffering, including the DSM's. These criticisms highlight some of the fundamental problems faced by those attempting to justify the conceptualisation of psychological suffering as 'mental disorder'.

2.2.3. Criticisms of Wakefield's 'harmful dysfunction' analysis

2.2.3.1 Assuming prior validity of 'mental disorders'

Boyle (2002, p. 96) notes that though "one of the fundamental tenets of scientific practice [is that] concepts must be tied to observable events . . . psychiatric concepts [are] not tied to observables in this way; that is, there [are] no clear rules for inferring them".

[12] The DSM assumes such dysfunctions, but no attempt is made to provide any analysis of how one would go about establishing the existence of these dysfunctions in order to utilise them as a means of determining the presence of 'mental disorder'. It is this that Wakefield aims to achieve with his 'harmful dysfunction analysis'.

Boyle (2002) notes that when this was pointed out by Hempel (a philosopher of science) the response of psychiatry was not to question whether the original concepts (i.e., the various 'mental disorders') were 'real' but to try to come up with 'operational definitions' for them. As Boyle (2002, p. 96) points out, this was not the correct way to proceed because

> in scientific activity, the observations or 'operations' come first and the concepts second as a consequence of them. Concepts developed this way come, as it were, ready equipped with correspondence rules; to suggest that it is reasonable to try to find these for existing concepts is nonsensical, a back-to-front view of research.

As Boyle (2002, p. 229) notes, Wakefield, like most others who attempt to define 'mental disorder', acts in this same 'back-to-front' manner by starting with an existing concept and "searching for a 'correct' set of correspondence rules[13] for inferring it".

Wakefield (1999b) justifies his 'back-to-front' approach by arguing that he, along with Spitzer and Endicott (Spitzer & Endicott, 1978) and Klein (1978, cited in Wakefield, 1999b), was simply "formulating theories to explain a distinction we already make". He goes on to suggest that

> such an analysis is successful if it meets the scientific objective of providing an adequate explanation of existing judgements about disorder and nondisorder. Such analyses do not stipulate how we *should* use 'mental disorder' but rather attempt to capture how we *do* use it.
>
> (Wakefield, 1999b, p. 1011, emphasis in the original)

Boyle (1990) notes that it is perfectly reasonable to study how people use terms like 'mental disorder' but points out that Wakefield seems to be trying to do a lot more than this. His suggestion that 'disorder' is a purely scientific concept, in that it exists "over and above value judgements" (Wakefield, 1999b, p. 1011) and his use of phrases like 'genuine disorders' or 'truly disordered' is part of a concerted effort to stipulate exactly *how* the concept 'mental disorder' should be understood rather than trying to 'capture how we *do use i*t'.

Wakefield, in spite of his claims to the contrary, and in common with most defenders of the Dysfunctional Mind Account, does not question the validity of the concept 'mental disorder', despite the difficulties surrounding it. Rather he sees his task as offering a more rigorous or more 'exact' definition of it. Boyle (2002, p. 229) suggests that this is like trying to come up with a more rigorous or more exact definition of sin

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[13] In the natural sciences correspondence rules specify what has to be observed before a concept can be inferred and "may specify quantitatively the relationship between variation in what is observed and variation in the inferred construct. The correspondence rules for the concept of intelligence, for example, specify the relationship between observable responses to items on a standardised test and 'amounts' of the unobservable concept, intelligence" (Boyle, 2002, p. 4). The 'correspondence rules' for 'mental disorders' are essentially the agreed-upon diagnostic criteria (as outlined in the DSM for example).

and then trying to provide a scientific basis for "common-sense distinctions between sin and other forms of wrong-doing". Boyle (2002, p. 229) further notes that

> [i]f this analogy seems strange it is only because in the twentieth and twenty-first centuries mental disorder has assumed a reality in Western culture almost as unquestioned as the reality of sin in earlier times; it is this assumed reality which makes it look as if the task of finding a scientifically based definition of mental disorder is reasonable.

2.2.3.2 What is a 'natural function' and how do we know it's dysfunctioning?

Wakefield (1992a; 1992b) suggests that in order to identify a dysfunction we first have to establish a mechanism's 'natural function' in order to know that it is failing to perform this function. For Wakefield, identifying a mechanism's 'natural function' is a purely scientific exercise involving no value judgements at all. Indeed, it is imperative for Wakefield's argument, that it be so or otherwise deciding whether a 'natural function' is dysfunctioning would have no scientific basis; rather it would be a value judgement.

A number of authors, however, challenge the notion that a 'natural function' can actually be defined value free (Fulford, 2001; Lilienfeld & Marino, 1995; Sadler & Agich, 1996; Wallace et al., 1997). As Sadler and Agich (Sadler & Agich, 1996, p. 224) point out, Wakefield's discussion of 'dysfunction' (in Wakefield, 1992a, p. 236) "reveals several value terms – beneficial, benefit, and failure – which are central to his analysis, yet resist restatement in descriptive terms". They go on to note that

> this is not surprising because functionalist definitions of disease (or disorder) naturally employ value terms in elaborating the concept of function. This unavoidable use of value terms partly explains why these accounts fail.
>
> (Sadler & Agich, 1996, p. 236)

Sadler & Agich (1996) also note that Wakefield's appeal to evolutionary biology to provide a value-free purely scientific basis for the concept of dysfunction is misguided. They suggest that Wakefield seems unaware that his interpretation of evolutionary theory, in particular his implication that organs or 'mental mechanisms' are 'intended' to or 'designed' to function in a particular way, is "itself contested by evolutionary biologists and philosophers of biology" (Sadler & Agich, 1996, p. 224).[14]

[14] A number of theorists (e.g., Gould, 1991, Piattelli-Palmarini, 1989, Williams, 1996, cited in Lilienfeld & Marino, 1995) have pointed out that many important physical systems were not actually designed by evolution to perform a particular function. Rather they were by-products of adaptations that have since

Wakefield also seems unaware that for evolutionary theory to do the job [he] expects, it, too, must be value-free. As Sadler and Agich (1996) argue, notions of 'design' or 'intention' (even if used 'metaphorically') cannot be 'value-free'. There are also fundamental questions over whether we can ever know the 'natural functions' of mental, or even physical, mechanisms, given our "incomplete and perhaps intrinsically limited knowledge regarding the natural origins of mental and physical systems" (Lilienfeld & Marino, 1995, p. 412).

Even if the notion of 'natural functions' was unproblematic, Wakefield fails to provide any means for directly establishing a means of distinguishing between natural functions and dysfunctions, as Boyle (2002) and Follette and Houts (1996) point out. Indeed, Wakefield acknowledges that "discovering what is in fact natural or dysfunctional may be extraordinarily difficult" (Wakefield, 1992a, p. 236).

Instead, Wakefield invokes the clinical experience of each individual mental health professional in order to decide whether a dysfunction is present or not. He suggests that in order to do this, clinicians would have to determine,

1. whether the response (symptoms) is so extreme "that nothing but the breakdown of internal mechanisms could be expected to cause them" (Wakefield, 1992a, p. 243) [in which case a mental dysfunction is present], or
2. whether the 'symptoms' are "a natural response that is initiated and maintained directly by the ongoing stress" (Wakefield, 1992a, p. 238) [in which case no mental dysfunction is present], or
3. whether the symptoms are a "normal, proportionate reaction to an unusual environmental stressor" (Wakefield, 1994, p. 646) [no mental dysfunction is present], or
4. whether the symptoms are caused by "the right kind of triggering stimuli" (Wakefield, 1994, p. 646) [mental dysfunction is present].

Such criteria, it seems, require omnipotence beyond the ken of even the best mental health professional. It presupposes the ability to look into every aspect of people's lives, from birth to the present, in all of the environments they live in (work, home, school, church, clubs, friendships, etc.), all the roles they play (father, lover, doctor, counsellor, friend, enemy, son), etc., etc. How else could one decide that a reaction was so 'extreme' it could only be caused by an 'internal dysfunction'? How else

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taken on functions different from their initial functions. For example, it has been argued that birds' feathers originally evolved to assist in heat insulation and only subsequently became helpful as a means of enabling flight (see Lilienfeld & Marino, 1995, p. 412).

could someone decide whether the symptoms were a 'natural response' to ongoing stress? How else could someone decide if something is a 'normal response to ongoing problems in living', or a 'normal, proportionate reaction to an unusual environmental stressor'?

Indeed, Wakefield's suggestion that clinicians could determine whether mental dysfunction is present or not by deciding whether something is a 'normal response' or an 'extreme' response is at odds with his own rejection of statistical deviance as a means of deciding whether a disorder exists or not (Wakefield, 1992b). If one cannot rely on statistics to alert one as to whether something is 'normal' or not then one is forced back on value judgements, which is precisely what Wakefield is trying to avoid with his use of the 'scientific' concept of dysfunction as the determiner of 'mental disorder'.

This has important implications for all metaphorist accounts of 'mental disorder' because to rest decisions about whether a 'natural function' is not functioning 'correctly' (i.e., whether someone has a 'mental disorder' or not) solely on value judgements is to place at risk psychiatry's scientific mandate to diagnose and treat these 'dysfunctions'.

This is the main reason why Wakefield's harmful dysfunction analysis has been seized upon by psychiatry, and some clinical psychology practitioners, with such enthusiasm; because it offers the possibility of 'scientific' proof that the problems that psychiatry and clinical psychology lay professional claim to are legitimate 'medical disorders'. If Wakefield's analysis (which is widely considered to be one of the most rigorous and 'scientific') does not, as is argued above, achieve this end, this raises questions not just about the conceptual validity of 'mental disorder', but the legitimacy of the entire Dysfunctional Mind Account approach to psychological suffering.

2.2.3.3 Difficulties with the 'harm' requirement

While Wakefield's (1992b, 383-384) harm requirement is considerably less problematic than his dysfunction requirement, not the least because it openly acknowledges that value judgements are involved, there are two important difficulties with it.

First, Wakefield does not clarify what he means by 'harm', which opens the way for systematic bias in these judgements. This is also a problem with other definitions of 'mental disorder' that include the criteria of 'harm', such as that provided by DSM-III (1980) (American Psychiatric Association, 1980) through IV-TR (American Psychiatric Association, 2000). As Boyle (2002) points out, socially dominant groups may be less

likely to see their own behaviour as harmful and thus less likely to evaluate it negatively, particularly if it is behaviour they enjoy or which is important in maintaining existing power relationships

Pantony and Caplan's (1991) attempts to get a new disorder, Delusional Dominating Personality Disorder, included in the DSM-III-R suggest that such definitional variation may indeed occur. The symptoms of this proposed disorder include

1. Inability to establish and maintain meaningful interpersonal relationships.
2. Inability to identify and express a range of feelings in oneself
3. Inability to respond appropriately and empathically to the feelings and needs of close associates and intimates
4. Tendency to use power, silence, withdrawal, and/or avoidance rather than negotiation in the face of interpersonal conflict or difficulty
5. Adoption of gender-specific locus-of-control (belief that women are responsible for the bad things that happen to one and the good things are due to one's own abilities and efforts).

(Adapted from Pantony & Caplan, 1991, p121)

The disorder can also include a number of delusions including "the delusion of personal entitlement to the services of a woman with whom one is personally associated" and the delusion that "women like to suffer and to be ordered around". As Pantony and Caplan (1991, p. 121) point out the symptoms of this disorder are

> stereotypically 'masculine' but are by no means exclusively applicable to males (nor do they characterize all males of course). The criteria clearly constitute a serious psychological problem.

It could be argued, using Wakefield's criteria, that this disorder constitutes a dysfunction of a 'natural mental mechanism', or several mental mechanisms (e.g., aggression inhibiting mechanisms, exploitation inhibiting mechanisms, impulse control mechanisms, socialisation mechanisms, mechanisms associated with learning, action, belief, thought, drive, and moral development[15], to name but a few). This disorder could also be argued to cause harm, both to those who suffer the disorder, and to those come into contact with the sufferer. Indeed, Pantony and Caplan's (1991, p. 129) primary point is that the kind of behaviours manifested by 'sufferers' of DDPD are "harmful to health".

[15] These 'mechanisms' have all been mooted by Wakefield in his various articles on the 'harmful dysfunction analysis' of mental disorder (see Section 2.2.3.5 for some examples).

The framers of the DSM-III-R, however, rejected this proposed disorder on the basis that there was not enough empirical support that it actually was a disorder, noting that "it is folly to open the floodgates to new and unsupported diagnoses" (Frances, 1989, p. 1, cited in Pantony & Caplan, 1991). Interestingly, the DSM-III-R retained two highly contested (and empirically unsupported) 'disorders', Self-defeating Personality Disorder and Late Luteal Phase Dysphoric Disorder, in an Appendix of categories needing further study. Both of these 'disorders' mislabel and pathologise female behaviours and feminine characteristics[16].

As Pantony and Caplan (1991, p. 120) point out "both categories were given official numbers and have, in fact, been treated in many ways as though they were full-fledged categories", despite the lack of evidence that they are 'disorders' and despite the objection of more than six million Americans and Canadians. It seems then, that certain harmful clusters of typically 'masculine' behaviours are perhaps less likely to be considered to be indicative of disorder than are other clusters, arguably less 'harmful' behaviours more typically 'feminine'. This example raises serious questions about the usefulness of Wakefield's 'harm' requirement as a means of deciding whether a disorder is present or not.

Another problem with the harm component of Wakefield's analysis, pointed out by Boyle (2002) is that having argued for its importance, Wakefield then proceeds to devalue it. For example, he implies that the concept of 'disorder' is a purely scientific one, in that it exists "over and above value judgements" (Wakefield, 1999b, p. 1011). This is despite the fact that Wakefield himself has argued that harm (which *does* require a value judgement) and dysfunction are *equally* necessary for a judgement of mental disorder. If this is the case then dysfunction (the supposedly value-free component) cannot be given precedence over harm. Indeed, Boyle (2002) accuses Wakefield of seeming to forget that he has made 'harm' a necessary part of his definition of mental disorder by essentially leaving it out of his analysis altogether.

2.2.3.4 Acceptance of 'mental disorders' as medical disorders

Wakefield defines 'mental disorders' as medical disorders in his analysis (e.g., Wakefield, 1999b). This claim, which is implicit in all versions of the Dysfunctional Mind Account (metaphorist, somaticist and biopsychosocial), is made explicit by Wakefield.

[16] Late-luteal phase dysphoric disorder has been re-named Pre-menstrual dysphoric disorder and is still in Appendix B (Criteria Sets and Axes for Further Study) of the DSM-IV-TR (American Psychiatric Association, 2000). Self-defeating personality disorder seems to have been removed from DSM-IV-TR.

For Wakefield, as for Clare (1976) and many other metaphorists, it is not necessary for 'mental disorders' to be shown to be biologically based for them to be legitimately included as medical disorders. Wakefield's (1999b, p. 1004-05) answer to those who question the conceptualisation of certain types of psychological suffering as 'medical disorders' is that

> [b]ecause the psychological systems with which the DSM and the mental health professions are concerned are biologically designed, DSM defined mental disorders are by definition a species of the general category of 'medical disorder' (which encompasses diseases, traumatic injuries and all other failures of normal functioning), analogous to digestive disorders and circulatory disorders.

Wakefield (1999b, p. 1007-08) goes on to suggest that because disorders are "failures of biologically designed functioning"

> [t]he judgement that 'something has gone wrong' with psychological functioning must be made relative to some baseline of things 'going right' and . . . evolution appears to be the only viable way to define the relevant baseline for how our minds are supposed to function. Evolution is part of biology, so disorders are biological.

As Boyle (2002) points out, however, this argument contains a number of assumptions that Wakefield makes no attempt to justify or support. These assumptions include:

1. that we have 'psychological systems' that have been 'biologically designed' by evolution to function in certain ways
2. that if our minds (psychological systems?) fail to function in the way they were 'designed' to that this would necessarily result in a 'mental disorder'. (Failure to function as designed could be adaptive in present circumstances, for example)
3. that because our psychological systems were 'biologically designed', dysfunctions of this system are inevitably going to be 'medical disorders' analogous to digestive and circulatory disorders.

Wakefield (1999b, p. 1004) does not explain what the "psychological system with which the DSM and the mental health professionals are concerned with" actually comprises. Nor does he provide any support (in any of his articles on this matter) for why we should believe that this 'psychological system' was 'designed' by evolution.

The notion that our 'psychological systems' (and this, in itself, is a problematic notion) are 'designed by evolution' is a highly contested claim (see for e.g., Panksepp & Panksepp, 2000; H. Rose & Rose, 2000) and one cannot simply treat it as a given. Indeed, given that Wakefield's entire analysis rests on the acceptance of this claim (it is, after all,

how one can 'scientifically' determine whether or not a dysfunction, and hence a 'disorder', is present) his failure to provide any real arguments to convince us of its verity is perplexing[17].

Finally, Wakefield does not provide any reasons why even if our 'psychological systems' were 'biologically designed' by evolution why dysfunctions of this system should necessarily be medical disorders. As Boyle (2000, p. 229) points out "we cannot assume in advance that when these [psychological systems] 'fail to perform as designed' the result will be conceptually identical to a 'failure' in a bodily mechanism". Wakefield seems to expect us to share his assumption that when something goes wrong with our lungs or our hearts this is conceptually the same as something going wrong with, for example, our 'loss-reaction regulating mechanism' or our 'moral development mechanism'.

What is more, Wakefield presents no evidence in support of the existence of these 'mental mechanisms' he constantly makes reference to, indeed he seems to invent them as he needs them. As has also been discussed above Wakefield fails to provide any support for his contention that it is possible to tell if mental mechanisms, even if such mechanisms could be proven to exist, are functioning as they were 'designed' to do or not.

2.2.3.5 Assumptions about the existence of 'mental mechanisms'

Underlying Wakefield's analysis, and most other metaphorist accounts of 'mental disorder', is the assumption that within every individual exist various 'mental mechanisms' suited to, or 'designed' for, the fulfilment of specific tasks or activities. In response to criticism of these assumptions, Wakefield (1999b, pp. 1012-13) has suggested that there are,

> in fact no special mentalistic assumptions . . . involved in my position on mental disorder. Mental disorders are simply psychological disorders; psychological disorders are disorders of psychological functioning; and, psychological functioning is simply a certain domain of functions (e.g., cognition, emotion, motivation, perception, intentional action) that are placed together under the same category of 'psychological functions' for complex reasons that are not relevant here. More or less everyone agrees that there are such functions and that there are internal mechanisms designed to perform them.

[17] It should be noted here that Wakefield claims he is basing his analysis on evolutionary biology but he is actually basing it on evolutionary psychology –an entirely different disciplinary area (allied to psychology rather than biology); an area whose knowledge claims are considerably more contested than those of evolutionary biology.

As Boyle (2002) points out, Wakefield's (1999, p. 1013) appeal to what 'more or less everyone agrees' is of no use in supporting his argument that "there are such [psychological] functions and that there are internal mechanisms designed to perform them". Boyle (2002) notes that Wakefield's assertion ignores the extensive and persistent controversy over whether such performative mechanisms exist (Karmiloff-Smith, 2000; S. Rose, 1997, 2000), as well as controversy over the relationship between our 'mental life' and our behaviour (Edwards & Potter, 1992; Gergen, 1999; Panksepp & Panksepp, 2000, 2001).

Wakefield, belying his assertion that there are no mentalistic assumptions in his account, provides a long list of the kind of mental mechanisms which might be implicated in mental disorder, including socialisation mechanisms, loss-reaction-regulating mechanisms, sadness-generating mechanisms, moral development mechanisms, anxiety regulating mechanisms and exploitation inhibiting mechanisms.

As Boyle (2002, p. 226) and Follette and Houts (1998) argue, these mechanisms, whose failure to function constitutes a 'mental disorder', seem to be simply invented as needed by Wakefield. For example, he suggests that conduct disorder may be caused by "a dysfunction of the moral development mechanisms" (Wakefield, 1997a, p. 648), and that depression is a condition where the symptoms may be caused by "a dysfunction in loss-reaction-regulating mechanisms, or sadness-generating mechanisms" (Wakefield, 1997a, p. 645).

Houts and Follette (1998, p. 855) ask:

> Where is the loss-response mechanism? Is it closer to the gain-response mechanism? And where are they? Is the sadness-generating mechanism located in the stomach or the throat? According to Wakefield's formulation where something must have gone wrong inside the organism, such hypothetical mechanisms must be invoked or else his formulation cannot distinguish genuine disorder from normal behavioural variation. Where biological psychiatry cannot yet supply the physical mechanism, Wakefield seems content to freely invoke mental mechanisms.

These mental mechanisms are a crucial aspect of Wakefield's account because according to his definition of 'mental disorder' people's problems are symptoms of 'disorder' only if those problems are caused by a dysfunctioning mechanism within the organism. Indeed, they are an important aspect, implicitly or explicitly, of all Dysfunctional Mind Accounts of 'mental disorder' because as pointed out by Wakefield (Wakefield, 1992b, p. 381) there is a "virtually universal tendency to fall back on dysfunction to explain disorder".

Without the existence of these 'mental mechanisms' what would it be that was dysfunctioning? A person's behaviour? A person's emotions? A person's social skills? A

person's ability to make their way in the world? If this was the case how could such dysfunctions be objectively determined in an entirely value-free way? And what would be the mandate for such dysfunctions to be conceptualised as 'mental disorders' and dealt with within a medically based framework?

Thus it is important, if Wakefield's account is to fulfil its own aim of providing an objective, scientific basis for discriminating true mental disorders from other human problems, that it fulfil three main requirements:

1. to establish that the various inferred mental mechanisms actually exist, and to establish what their normal functioning is
2. to establish that a particular mechanism (or mechanisms) has actually dysfunctioned and
3. to establish how this dysfunction has led to the problem with which the person is presenting.

As has already been noted above, Wakefield fails to fulfil requirement (a) because he seems content to invent various 'mental mechanisms' when and as needed. As Boyle (2002, p. 226) notes, the existence of these 'mental mechanisms' are

> inferred in a circular fashion from the behaviour that the mechanism is then used to explain; there seems to be no independent means of inferring the mechanisms without reference to the supposed effects used to posit their existence in the first place.

Boyle (2002) notes that Wakefield cannot see the tautology here because he takes the existence of these mental mechanisms as given.

Because Wakefield cannot establish the existence, or the normal functioning, of these mental mechanisms he is unable to establish that a particular mechanism (or mechanisms) has actually dysfunctioned (requirement b), and he is also unable to establish how this dysfunction has led to the particular problem (e.g., chronic sadness, suicidal thoughts, obsessions, compulsions, disobedience, hyperactivity, insomnia, anxiety, etc., etc.) that a person may be suffering from (requirement c).

This failure to definitively establish how a certain 'dysfunction' (or neurochemical / neuroanatomical / genetic / cognitive / behavioural difference) actually causes the suffering in question is a problem for all Dysfunctional Mind Accounts of psychological suffering and highlights the importance of seeking 'understanding' rather than 'explanation'.

Indeed, Wakefield (1997a, p. 647) himself acknowledges that many presuppositions concerning mental mechanisms are "inchoate" but suggests that this "encourages us to start being more explicit in formulating, evaluating, and improving these assumptions". Unfortunately, until this is done (assuming it actually can be done, see Lilienfeld & Marino, 1995), Wakefield's analysis, based as it is upon the inferred existence, and inferred dysfunctioning, of such 'inchoate' mechanisms, fails as a means of objectively determining the existence (or not) of 'mental disorders'.

2.2.4. Conclusions

Despite having made what Sadler and Agich (1996, p. 221, authors' italics) describe as "the most sustained and articulate application of disorder and dysfunction concepts to *psychiatric classification* in the literature" Wakefield has nevertheless failed in his attempt to provide a 'scientific' and 'value-free' analysis of 'mental disorder'. This failure indicates just how difficult it is to define and defend the concept, particularly within a primarily metaphorist framework.

These difficulties essentially arise because words such as 'disorder', 'illness' and 'disease' are lay or social terms and, as Boyle (2002, p. 222) points out, "they can no more have a proper or correct definition or tell us how to think about those to whom the terms are applied, than terms like 'courage' or 'sin'". Boyle (2002, p. 222, author's italics) goes on to note that

> trying to identify people who have mental disorders makes no more sense than trying to identify people who are definitely courageous or sinful. This is not to suggest there is no agreed or correct usage of these terms, simply that no usage can be thought of as correct or definitive or tell us which theoretical frameworks to use in trying to understand whatever behaviours led us to apply the terms in the first place.

In other words, the concept of 'mental disorder' is no more than just one among many ways of talking about psychological suffering. The fact that this 'way of talking' is led by a particularly powerful group in our society (medical doctors) does not make the concept any more 'scientifically' valid. As Boyle (2002, p. 231) puts it

> [t]he entire enterprise of defining mental disorder is pointless, at least in so far as the goal is to allow us to recognise 'genuine' or 'true' disorders. Indeed, attempts to define 'mental illness/disease/disorder' can be seen as attempts to prove that we ought to respond to certain behaviours and experiences as if they were unwanted bodily phenomena in the absence of evidence that this is a valid and useful way of proceeding.

Before proceeding to the next section it is necessary to note that while I have discussed in some detail the problems inherent in the general concept of 'mental

disorder' I have not looked in any detail at the problems surrounding the various discrete diagnostic categories (e.g., schizophrenia, depression, bi-polar disorder, etc.) contained within the DSM-IV. Suffice to say, perhaps not surprisingly given the difficulties surrounding the general concept of 'mental disorder', that psychiatric diagnoses fail the first major test of whether they are defining anything 'real' in that, as Bentall (2004, p. 68) points out, "for the most part [they] fail to meet adequate standards of reliability". Essentially this means that psychiatrists and psychologists often cannot agree whether a person is suffering from Disorder A or Disorder B.

Further, reliability alone cannot ensure a diagnostic system is categorising anything 'real'. As Bentall (2004) notes, further tests of the system must be done to ascertain its validity. We can evaluate the validity of diagnostic categories by asking whether they help us to reach useful insights about a problem, or if they help us to make predictions about what course a particular problem might take (Bentall, 2004).

While I will discuss some of these issues, as they relate to the Dysfunctional Mind Account in general, rather than to specific 'disorders' in Section 2.3, it should be noted, as Bentall (2004, p. 68) points out, that

> a diagnostic system cannot be valid without first being reliable. Unless psychiatrists and psychologists can agree about which patients suffer from which disorders there is no possibility that the process of diagnosis will fulfil any useful function.

It is suggested that difficulties reaching an agreement about who suffers from what disorder are inevitable given the problems, outlined in some detail above, inherent in the general concept of 'mental disorder'. I will, however, return to some of the issues surrounding individual diagnoses in Chapter Six when I attempt to apply the alternative analysis generated in Chapter Six to understanding the experiences and the behaviours involved in two specific 'mental disorders' – 'schizophrenia' and 'depression'.

2.3. PRACTICAL UTILITY OF THE DYSFUNCTIONAL MIND ACCOUNT

Clearly the DMA is difficult to justify theoretically, with little support for its central tenet – that certain types of psychological suffering are 'mental illnesses'; discrete disorders which can be distinguished from other types of psychological suffering and from each other. The DMA has also failed to provide any real understanding of the causes of the kinds of suffering called 'mental disorder'. But what about its practical

utility? Does the DMA lead to strategies that result in the alleviation of psychological suffering for those who seek help? Perhaps even more importantly, does the DMA lead to strategies for preventing such suffering in the first place?

It should be noted here that the DMA views the individual as the primary locus of his or her problems. As Hare-Mustin & Marecek (1997, p. 114) point out

> The presumption underlying most forms of treatment is that what is wrong lies within the individual, and external conditions do not need to be addressed or modified. Traditional treatment approaches take as their task helping people to adjust to their circumstances rather than transforming those circumstances that contribute to and are part of the problem.

Smail (1987, p. viii, author's italics) suggests that the individualistic bias of mainstream approaches to psychological suffering is exacerbated by

> the apparent indubitability of our personal experience – our intimate knowledge of our feelings – which makes it so difficult for us to conceive of the source of our difficulties as *outside* ourselves. We *feel* it inside, so we think that that is where it must indeed originate, and we are, therefore, easily persuaded [by mental health professionals and others] that it is *we* who are responsible for what ails us.

Because of this individualist bias attempts to alleviate psychological suffering within the Dysfunctional Mind Account framework tend to focus almost entirely on the individual. Such attempts, due to the DMA's medical model grounding, are usually referred to as 'treatments' and focus on either the body (e.g., pharmaceuticals, Electro-convulsive therapy, psychosurgery) or on the 'mind' (psychotherapy, group therapy).

2.3.1. Does it succeed in alleviating or 'curing' suffering?

Physical treatments: Pharmaceuticals

As has been pointed out by a number of writers the percentage of people who are helped by pharmaceuticals is much lower than is commonly claimed and many people also experience a number of adverse side effects (Antonuccio, Danton, & McClanahan, 2003; Breggin, 1991; Pilgrim & Rogers, 1999; Valenstein, 1998; Whitfield, 2004). Whitfield (2004) notes that research has shown one-third to two-thirds of people who take antidepressant drugs are not helped by these drugs. Antonuccio, Burns and Danton (2002, cited in Antonuccio et al., 2003, p. 1029), talking specifically about the new selective serotonin reuptake inhibitors, also note that

> although [these drugs] are widely thought to be extremely effective and safe, there is mounting evidence that their benefits have been overemphasized in the scientific literature.

Furthermore, a recent study (Kirsch et al., 2008) indicates that that SSRIs (selective serotonin reuptake inhibitors) are no more useful than a placebo for the majority of those taking them. The only exception occurs for the most severely depressed patients, although according to the authors this is probably because the placebo stopped working so well rather than the drugs having worked better. As the Head of the Department of Psychological Medicine at the Christchurch School of Medicine, Professor Roger Mulder admitted to a journalist writing about 'depression',

> All we really know is how to treat depression in the first six weeks. After that there's very limited understanding of what you do when the first treatment fails, how long people should be on medication - it's pretty much clinical folklore rather than real data. But we are starting to realise that the outcome is not as good as people hoped.
>
> (Mulder, cited by Philp, 2001, p. 21)

A review by Fisher and Greenberg (cited in Pilgrim & Rogers, 1999) makes the same point about the major tranquilisers (also called 'neuroleptics' and 'antipsychotics') used to treat schizophrenia. This review suggests that two out of three medicated patients suffer relapse and that long-term use leads to 'reduced social functioning'. Another review (Cohen, 1997, cited in Rogers & Pilgrim, 1999, p. 126) concludes that "the overall usefulness [of major tranquilisers] in the treatment of schizophrenia . . . is far from established" and goes on to note that their "near sacred reputation as 'antipsychotics' is equalled only by their record as one of the most behaviourally toxic classes of psychotropic drugs".

As has been noted by Healy (2001) in a lecture he presented at a Symposium at the University of Toronto.[18]

> If our drugs really worked, we shouldn't have 3 times the number of patients detained now compared with before, 15 times the number of admissions and lengthier service bed stays for mood and other disorders that we have now. This isn't what happened in the case of a treatment that works, such as penicillin for GPI [General Pariesis Insanity]

It should be noted here that one of the major reasons why many people, both medical practitioners and lay-people, think that drugs are considerably more efficacious than they are in the alleviation of psychological suffering is that pharmaceutical companies work very hard to ensure their products are seen in a positive light. As many commentators have noted, the pharmaceutical industry is very large, and very powerful

[18] Healy had recently been appointed Clinical Director of the Mood and Anxiety Disorders Program and as a Full Professor in the Department of Psychiatry at the University of Toronto but shortly after this speech was delivered his job offer was withdrawn.

– economically and politically (Antonuccio et al., 2003; Healy, 2001; Valenstein, 1998). Indeed, as Antonuccio et al. (2003) point out

> it is the most profitable industry in the United States in terms of return on revenues, return on assets and return on equity.

The industry spends a considerable amount of money to influence the opinions and behaviours of doctors (including psychiatrists) and the public and the "the effectiveness of their marketing strategies cannot be overestimated" (Valenstein, 1998, p. 166).

It should also be noted that the profit motive of these companies works against the truthful reporting of research outcomes (Breggin, 1991; Healy, 2001; Valenstein, 1998; Whitfield, 2004). As Valenstein (1998, p. 189) emphasises, the pharmaceutical industry invests a considerable amount of money sponsoring biomedical research in universities, hospitals and medical schools and notes that because such companies do not want to see their investment wasted

> there are clear dangers when they are in a position to influence the way trials are conducted and the way data are presented

Valenstein (1996) further notes that studies of clinical trials have shown that

> those supported by pharmaceutical companies are more likely to report results favourable to a company's products. One review of more than one hundred controlled clinical trials published in five leading medical journals found that those funded by pharmaceutical companies were much more likely to conclude that the new drug had advantages over a traditional treatment than were studies funded by government agencies.

Drug companies almost always exaggerate the efficacy of their own drugs while minimising any adverse side effects. This is done by citing on the studies that show their product in the best light, and by "putting their own 'spin' on the way data are presented" (Valenstein, 1996, p. 189). As Healy (2001, p8) notes

> a large number of clinical trials are not reported if the results don't suit the companies' sponsoring study. Other trials are multiply reported so that anyone trying to meta-analyse the findings can have a real problem trying to work out how many trials there have been. Within the studies that are reported, data such as quality of life scale results on antidepressants have been almost uniformly suppressed. To call this science is misleading.

It seems that the ability of pharmaceuticals to alleviate psychological suffering is considerably more limited than the 'hype' which surrounds them would suggest and it is difficult not to conclude that drug company marketing contributes more to the increasing use of pharmaceuticals for the treatment of 'mental disorders' than the efficacy of the drugs themselves.

It must be acknowledged at this point, however, that while undeniably 'over-hyped' psychiatric drugs do provide, in some cases, relief from suffering for those diagnosed with 'mental illnesses'. As Moncrieff (2005) notes, however, this does not mean that these drugs are correcting 'chemical imbalances' in the brain, or acting directly on any other underlying 'pathologies' hypothesised to be 'causing' the suffering. Rather, Moncrieff (2005, p 146) suggests that what psychiatric drugs are doing is inducing

> characteristic physiological and subjective states that may, or may not, be experienced as useful in certain social and interpersonal situations, including clinical situations

Some of these subjective states may provide relief for certain aspects of the suffering a person is experiencing. Moncrieff (2005) illustrates her point with the example of alcohol, a drug that results in certain characteristic physiological and behavioural effects and subjective experiences. She suggests that because of its characteristic disinhibiting effects

> it may be seen as a possible treatment for 'social phobia', not because the substance corrects an underlying physical abnormality in social phobia, but because one type of effect produced by alcohol might in itself be useful for people experiencing difficulties in some interpersonal or social situations
>
> Moncrieff (2005, p 147)

To further support this contention Moncrieff (2005) cites research that describes "dramatic beneficial effects of ethyl alcohol on patients with schizophrenia" (Sullivan, 1962, Lehman, 1989, cited in Moncrieff, 2005).

Physical treatments: ECT

Electroconvulsive therapy (ECT) involves the passing of electricity through the brain to cause a seizure. This is done due to a belief that the seizure will alleviate the suffering associated with various 'mental illnesses', in particular depression and schizophrenia. As was noted in the review of ECT carried out by New Zealand's Ministry of Health (2004, p. 1)

> most studies [assessing the efficacy of ECT] have had poor design features, such as small samples of patients and inappropriate methods of statistical analysis, which increase the likelihood of bias (i.e. error) occurring when assessing associations between ECT and outcomes . . . There are few ideal RCTs of ECT.

The review (Ministry of Health, 2004, p. 1) also acknowledges that

> there are risks associated with the general anaesthesia administered before ECT. These are mainly related to the cardiorespiratory system. Special care should be taken when

> administrating ECT to people with existing cardiac disease. ECT should only be administered by medical practitioners appropriately trained and experienced in the technique, including use of general anaesthesia. Headache and minor confusion are common immediately following ECT. Older patients are at a higher risk of falls and injury when confused. Many patients experience disturbances in memory following ECT. These disturbances usually resolve within a few weeks for most patients. A minority of patients experience long-term effects on memory, which is subjective and difficult to measure.

Despite its acknowledgement that ECT is a potentially dangerous treatment and that the scientific evidence on which efficacy claims for ECT are based is scant the Report recommended that ECT continue to be utilised as a treatment for severe 'mental disorders' in New Zealand.

Psychologist John Read (2004), who presented a submission in opposition to the continuation of ECT in New Zealand, questions the report's conclusion that 'ECT is an effective treatment' and notes that the Report itself acknowledges that there are no studies showing any lasting benefits of ECT beyond a few weeks . Read (2004, p. 1), points out that his review of the literature and the three other research reviews he submitted to the Committee

> document the serious methodological flaws in the few studies that claim even a short-term advantage of ECT over simulated-ECT (i.e. general anaesthetic without the electricity or convulsion - the appropriate placebo control for such studies). The Report also acknowledges [7.1] that there is only one properly designed efficacy study that has ever followed up patients for six months and that this study 'showed a trend in favour of simulated ECT.'

Read (2004, p. 2) also notes that the Report concluded that "there is no definitive randomized evidence that ECT prevents suicide" (Ministry of Health, 2004, p 11) and suggests that

> It seems illogical, therefore, that the Report goes on, despite this lack of evidence, to recommend that ECT should be used when patients are 'at a high risk of suicide'. [7.1.A].

Read (2004, p. 2) also notes that

> this sort of logical inconsistency is evidenced at several other points in the Report. For example, despite rightly concluding that 'there is insufficient evidence to draw firm conclusions about the efficacy of ECT in mania' [7.3] the Report goes on to recommend its use for mania anyway.

Breggin (1991, p 206), an American psychiatrist and critic of ECT, also questions the acceptance of ECT by psychiatrists and health authorities. Breggin (1991) notes that

> [a] thorough review of the shock literature shows that there are no controlled studies indicating any 'beneficial' effect beyond four weeks. Most show little or no improvement at all.

Breggin (1991, p 207) goes on to note that this point was proven at a conference on ECT held by NIMH (National Institute of Mental Health) and NIH (National Institute of Health)

> at which psychologist and attorney Edward Opton Jr., presented his [critical] review. When none of the assembled shock doctors could provide any contradictory evidence, his conclusions were accepted in the Consensus Conference panel report, "Electroconvulsive Therapy", published in the October 18, 1985, *Journal of the American Medical Association*.

Breggin (1991) notes, however, that Opton's report was excluded from publication in the proceedings of the NIMH Consensus Conference. Breggin (1991) also cites a study by Crow and Johnstone (1986), published in the 1986 New York Academy of Science proceedings, which concludes

> Whether electrically induced convulsions exert therapeutic effects in certain types of depression . . . has yet to be clearly established.
>
> (Crow & Johnstone, 1986, cited in Breggin, 1991, p 207)

As Breggin (1991, p. 206) points out, "this is a most remarkable conclusion from the heart of the establishment"[19]. Breggin (1991) further notes that the conclusions of Crow and Johnstone were omitted from the American Psychiatric Association's task force report *The Practice of Electroconvulsive Therapy*, which, according to Breggin (1991, p. 206), "carefully paints an unblemished portrait of ECT in order to promote the treatment and to protect psychiatrists against malpractice suits".

It is difficult not to conclude that mental health professionals and government bodies are determined to continue with the practice of ECT despite the fact that there is very little evidence to suggest that it is efficacious and a considerable amount of evidence to suggest that it causes ongoing harm to recipients.

Physical treatments: Psychosurgery

According to the Oxford Textbook of Psychiatry (Gelder, Gath, Mayou, & Cowen, 1996, p. 598) psychosurgery is

> the use of neurosurgical procedures to modify the symptoms of psychiatric illness by operating on either the nuclei of the brain or the white matter.

Psychosurgery began in 1936 with the work of Moniz and continued to be enthusiastically endorsed, and utilised, by psychiatry until the 1970s. Psychosurgery fell out of favour due to growing evidence of adverse 'side-effects' including intellectual

[19] Timothy Crow is an eminent British biological psychiatrist.

impairment, emotional lability, disinhibition, apathy, incontinence, obesity, and epilepsy (Gelder et. al., 1996). Advances in pharmacology also contributed to its fall from grace. It is, however, still used in some countries for "intractable mood disorder, obsessive-compulsive disorder, and anxiety disorder" (Gelder et al., 1996, p. 599).

Less invasive techniques such as deep brain stimulation (implanting electrodes in a person's brain, or in a nerve in their neck, and connecting them to a pulse generator implant placed under the skin of their chest) have arisen as possible alternatives to psychosurgery. The research on deep brain stimulation as a treatment for depression is still in its early stages but the technique is causing the same kind of excitement aroused by the lobotomy in the 1930s.

There are currently two ways of delivering Deep Brain Stimulation to patients, the first is to implant electrodes directly in a person's brain and the second is to implant electrodes into a patient's vagus nerve in their neck. In both methods the electrodes are controlled by a device placed under the skin of their chest that controls the amount of 'stimulation' the brain receives.

The first method was pioneered by neurologist Helen Mayberg and publication of the first research results (Mayberg et al., 2005) received considerable media attention. A Google Search for 'brain pacemaker'[20] (depression) brought up 343,000 articles. The majority of those sampled were very positive about the new technique with little or no acknowledgement of the continuing controversy over whether it actually works. The excerpts below are typical of the tone of these articles:

> **Pacemaker 'cure for depression**: Scientists claim to have developed a "brain pacemaker" that can cure depression through an electronic stimulus. The discovery raises hopes for thousands for release from depression by drilling holes into their skull and attaching electrodes to the brain which can create a brighter mood.
>
> (L. Gray, 2005)

> **Implanted brain pacemaker treats depression**: A "pacemaker" implanted in the brain appears to help severely depressed patients who don't respond to other treatments. In a small but potentially landmark study, four out of six formerly treatment-resistant patients got better after electrodes were implanted in a region of their brains thought to drive depression.
>
> (S. Boyle, 2005)

> **Brain pacemaker lifts depression**: Fitting patients with a brain pacemaker could switch off hard-to-treat depression, believe UK experts.

[20] The term used by many in the media to refer to Deep Brain Stimulation techniques of this sort

(BBC News, 2005)

This study involved six people, four of whom were reported to have experienced 'significant improvements' in their mood. These improvements lasted for the six-month duration of the study. Two of the six lapsed back into depression. Media reports were upbeat about the two non-responders, however, with many of them noting that "scientists believe that fine-tuning the implant treatment could eventually cure most cases of severe depression" (Chittenden, 2005; L. Gray, 2005).

What none of the media reports located in the Google Search noted, however, was that the two men who didn't respond to the treatment also

> developed local infections related to the connector cable at the chest (patient 2) or scalp (patient 4). Both were treated with intravenous antibiotics. Because of persistent infection in the absence of clinical benefit, the devices were explanted at approximately 6 months with resolution of their infections.
>
> (Mayberg et al., 2005)

The media reports located also failed to note the considerable limitations of this study – the most important of which was that no sham surgery or systematic placebo control arm was used. To properly evaluate the effectiveness of a procedure of this type including a control group who are subjected to the same surgical procedure is vital. The effects on the people involved in this experiment of being subjected to such a highly technical, 'cutting edge' procedure carried out by expert neurologists and neuro-surgeons with the promise of 'curing' their depression cannot be underestimated. The sample size of the study was also extremely small and the duration of the study, six months, very short, particularly given that depression tends to wax and wane naturally over time for most people (Gotlib & Hammen, 1992).

The other method of delivering Deep Brain Stimulation involves implanting a device in the vagus nerve of a person's neck. This device, called a vagus nerve stimulator, was approved by the United States Food and Drug Administration (FDA), in July 2005 as a treatment for depressed adults who had tried four other treatments and were still depressed (Boodman, 2006; D. Gray, 2006).

As noted by an article in *The Washington Post* (Boodman, 2006), however,

> the only rigorous clinical trial of the device -- which is approved to treat severe epilepsy -- failed to demonstrate effectiveness in alleviating depression. That study involved 235 patients, all of whom received the device, which was turned on in only half the group. At the end of three months, there was no statistically significant difference between the two groups.
>
> A second study of 174 VNS recipients found that 30 percent showed significant improvement after one year. Because that study lacked a control group and because patients received other depression treatments after the device was implanted, there is no

> way to know whether the device was responsible. For years experts have known that depression -- unlike, say, type 1 diabetes -- can get better without treatment.

As well as not having been proved to be effective in alleviating depression VNS also causes many patients to lose their voice and to feel persistent constriction in the back of their throats. Once implanted the electrodes in a patient's neck must remain forever due to tissue growing around them. As a result of this VNS recipients often cannot undergo a full body MRI or a therapeutic ultrasound (Boodman, 2006). Worsening depression and suicide attempts have also been reported by one-third of patients in a study funded by Cyberonics (the company selling the VNS device), according to data presented to the FDA (Boodman, 2006).

Again, as with psychopharmaceuticals, psychosurgical procedures seem to be considerably less efficacious at alleviating psychological suffering than people have been led to believe.

Psychological treatments: Individual psychotherapy

The effectiveness of psychotherapy is notoriously difficult to pin down, due to the massive influence of interpersonal factors. As Pilgrim and Rogers (1999, p. 128) point out

> Good outcome in therapy is not linked to particular models but to these benign, supportive or inspirational practitioner variables
>
> (Pilgrim & Rogers, 1999, p. 128)

Nevertheless a number of studies suggest that psychotherapy is only marginally effective at best (Bergin & Lambert, 1978, cited in Pilgrim & Rogers, 1999) while others suggest that not only is it not effective, but it can also have detrimental effects (Masson, 1994; Pilgrim & Rogers, 1999; Smail, 1987)

Pilgrim and Rogers (1999) point out some of these detrimental effects. These authors note that many clients in psychotherapy experience what is known as the 'deterioration effect' where symptoms get worse during the course of therapy. They also note that personal change can be held back, rather than accelerated, while in therapy due to the patient role reinforcing passivity and dependency.

Another problem with therapy pointed out by Pilgrim and Rogers (1999, p. 128) is the possibility of encountering an unethical therapist who exploits "the power discrepancy existing, under conditions of privacy, to gain emotional or sexual gratification from their clients." A review by Schoener and Lupker (1996, cited in

Pilgrim & Rogers, 1999) found that in the US over half of the malpractice suits brought against psychiatrists and clinical psychologists involve sexual abuse by therapists.

Another difficulty with psychotherapy is that it is time-consuming and thus expensive. Albee and Ryan-Finn (1994) cite a study by Kiesler and Morton (1987, cited in Albee & Ryan-Finn, 1994, p. 82) that established

> the unbridgeable gap between the small number of professionals available to treat and the large numbers needing treatment. Those with the most serious mental and emotional problems (the poor) are not covered by health insurance and cannot afford therapy.

Albee and Ryan-Finn (1994) also point out that those groups with the most mental health problems are also the least likely to seek help in the form of psychotherapy. They further note that even if these groups were able to access therapy it would do little to alleviate the effects of stressors such as chronic poverty, social isolation, inadequate education and weak cultural ties.

Indeed, the above discussion suggests that a Dysfunctional Mind Account approach to psychological suffering is not particularly effective at alleviating or ending such suffering regardless of what treatment modality is employed. As Pilgrim and Rogers (1999, p. 129) note

> No form of treatment claims startling improvement rates (let alone 'cure') . . . [g]iven this poor showing in symptom reduction, the iatrogenic effects of treatment become particularly salient. 'Side-effects' might be tolerated if significant therapeutic benefits were also experienced by patients but with high iatrogenic effect rates and low symptom reduction rates, treatments become highly problematic.

2.3.2. Does it succeed in preventing suffering?

As has already been pointed out in the Introduction to this thesis, research suggests that the incidence rates for the experiences referred to as 'mental illnesses' are rising (Eckersley, 2004; Hagnell, Lanke, Rorseman, & Ojesjo, 1982; Schumaker, 2001; Seligman, 1990). This rise in the incidence of psychological suffering is reflected in rising suicide rates in Western societies (Eckersley, 2004; Public Health Group, 1996; Schumaker, 2001), with Schumaker (2001) pointing out that between 1960 and 1973 suicide rates doubled in the 15-24 age group in the United States and tripled for young black people.

A recent nationwide survey carried out in New Zealand (Oakley-Browne, Wells, & Scott, 2006) found that 39.5% of New Zealanders had suffered from a 'mental disorder' at some time in their lives and 20.7% had suffered from one in the last twelve

months. The research suggested that 46.6% of the population in New Zealand will meet criteria for a disorder at some time in their lives. Of the respondents 15.7% had thought seriously about suicide, 5.5% had made a suicide plan and 4.5% had attempted suicide.

The Global Burden of Disease Study (Murray & Lopez, 1996, cited in National Institute of Mental Health, 2001) found that 'mental illness', including suicide, accounts for over 15 percent of the burden of disease in established market economies. This is more than the disease burden caused by all cancers. This study found depression to be the leading cause of disability worldwide among persons aged five years and older.

Oakley-Brown (2006) found anxiety and depression to be the two most commonly experienced 'mental disorders' with 24.9% of people reporting that they had experienced an anxiety disorder at some time in their lives and 20.2% of people reporting that they had experienced a mood disorder. As Schumaker (2001) points out, the prevalence of these two disorders in the West has become accepted wisdom, so much so that until recently we were considered to be in the 'Age of Anxiety' and now we are considered to be in the 'Age of Depression'.

Levine (2001) notes, in relation to the ubiquity of anxiety disorders in the United States, that in December 1999 the Surgeon General reported that in any given year 16.4% of Americans between the ages of 18 and 54 will suffer from anxiety disorders (ref, cited in Levine) while the American Psychiatric Association, in the same year, suggested that one in eight Americans, in their lifetime, will suffer from social phobia (ref, cited in Levine). Levine (2001) also notes that in 1988 the National Institute of Mental Health reported that obsessive-compulsive disorder (OCD) could be 25 to 60 times as common as previously supposed and that 6.2% of American adults were taking benzodiazepine tranquilisers in 1994 (see Levine, 2001). Two meta-analyses, carried out by Twenge (Twenge, 2000) found that Americans have become substantially more anxious and neurotic since the 1950s with the average American child reporting more anxiety in the 1980s than child psychiatric patients in the 1950s.

A considerable body of research also testifies to the high rates of depression in the industrialised West. Martin Seligman (1990) analysed a number of studies of rates of depression, including several well-controlled longitudinal studies, and concluded that depression is approximately ten times as common as it was only fifty years ago. A similar conclusion was reached by Hagnell and his colleagues who, after reviewing the literature on depression (1982, p. 279), concluded "it now appears as if the prevalence of depression is reaching epidemic proportions". In the face of this escalation the DMA, it seems, is not proving itself to be effective at preventing 'mental disorder'.

Cross-cultural and anthropological research further illustrates the DMA's inability to make any impact on the rising numbers of people suffering from 'mental illness'. Such research suggests that many, if not all, of the 'mental disorders' listed in the Diagnostic and Statistical Manual are considerably less common in non-Western or 'traditional' societies than they are the West (where the DMA is the predominant conceptualisation of psychological suffering). Schumaker (2001, p. 55) notes, in the case of depression, that

> a broad generalization can be made about so-called clinical depression when it is examined in a wide cross-cultural context. In its full form, which entails an extensive psychological and cognitive component (e.g., sadness, self-doubt, self-denigration, guilt, personal worthlessness and low self-esteem, social withdrawal, loss of interest in life), clinical depression appears to be limited to Western culture. In non-Westernized cultures, there is little or no evidence for clinical depression as it is described in our diagnostic manuals. A great many of them have no words that describe depression as we know it.

Schumaker (2001) also notes that

> [t]here exists extensive cross-cultural variation with regard to the general magnitude of anxiety, as well as the prevalence of anxiety disorders. Indeed, there have been some striking observations made on this subject in different cultures. In a study of 2,360 Yoruba Aboriginals of Australia, not a single case of overt anxiety was found. No indications whatsoever were found of such specific anxiety disorders as phobia or obsessive-compulsive disorder.

Western researchers, working within a DMA framework have tended to resist such findings and instead suggest that depression and anxiety are present in all cultures but that that these 'disorders' are expressed in different ways. In the case of depression, for example, this has involved the creation of a sub-type that has only the somatic symptoms such as headaches, and problems with sleep and digestion. Interestingly these 'symptoms' almost always accompany stress and no one is arguing that people of other cultures do not suffer from stress at one time or another. It is what they 'do' with that stress that is at issue and it appears that 'depression', as it is conceptualised in the West, is not a common response to stress in non-Western cultures.

As Schumaker (2001, 56) points out

> [t]he claim that clinical depression is universal or inevitable does not stand up well to anthropological research that demonstrates that entire societies can be found that do not suffer from this type of psychopathology. An examination of their cultural structures can tell us a great deal about the nature of depression, as well as the viability of our current theoretical formulations.

Almost without exception research suggests that the rates of 'mental illness' are continually increasing in Western industrialised nations. Even if, as suggested by Healey et al. (2001) mental health researchers over-inflate the numbers of people suffering from the various disorders in order to generate more income and status for themselves, these

findings raise considerable questions about the way we are currently dealing with the kinds of suffering conceptualised as 'mental illness'.

It seems an inescapable conclusion that the Dysfunctional Mind Account approach to psychological suffering does not lead to strategies that have resulted in the prevention of psychological suffering. Instead, the rate of 'mental disorders' in Western populations seems to have risen precipitously over the last fifty years or so, a rise which shows no sign of abating despite the huge amounts of money poured into research into discovering the causes of 'mental illness', or new treatments (most often pharmacological) to alleviate or 'cure' it.

It is not surprising that the DMA has not had much success at preventing mental disorders given its profoundly individualistic focus. Such a focus actively mitigates against efforts to reduce the incidence of 'mental illness' because to be effective such efforts must be made at a societal level, not just at an individual level. As Albee and Ryan-Finn (Albee & Ryan-Finn, 1994, p. 81) point out

> [i]t is a well-established public health doctrine, proven repeatedly, that no mass disorder afflicting humankind has ever been eliminated, or even brought under control, by attempts at treating affected individuals.

Albee and Ryan-Finn (1994, p. 81) go on to note that

> the strategies of primary prevention of mental and emotional disorders are essentially the same as the strategies of prevention of physical illness and disease. One of the effective strategies is to *discover the noxious agent* and take steps to eliminate it or reduce it. A second strategy is to *strengthen the resistance of the host* to the noxious agent. In the field of mental health the noxious agent frequently is excessive stress. Often the stress results from powerlessness, exploitation, poverty and hopelessness.

Efforts at prevention, if they are made at all, tend to be focused, as Albee & Ryan-Finn (1994, pp. 81-82) note, almost exclusively on

> individual resistance to stressors at the expense of societal reforms, and some programs would be more aptly viewed as early intervention.

2.4. CONCLUSION

It has been argued in this chapter that the DMA is difficult to justify both theoretically and practically. Despite the considerable amount of research devoted to the various 'mental disorders' there is still a disturbing lack of clarity about just what sort of 'phenomena' these 'disorders' are, where they come from, how best to help those

who suffer them and how to prevent them occurring in the first place. The response from psychiatry to this criticism tends to be to point out that the research programme currently being pursued with such vigour (focusing primarily on the individual and, in particular, their biology) will eventually bear fruit and that "just round the corner lies some vital new fact which will settle the arguments for once and for all" (Ingleby, 1980, p. 23).

As Ingleby (1980) points out, however, it is not the sheer volume of research findings that count, but the "principles which govern the acquisition and interpretation of the findings". As Ingleby (1980, p. 23) notes,

> . . . a science whose conceptual foundations have not been properly thought out is doomed to collapse, no matter what volume of findings is stacked up above them. What we need, then, are not more findings – we probably have all we need, if only we knew what to do with them – but a reappraisal of the kind of explanations we should be looking for, and the kind of data that would be relevant to them. The 'great debate' in psychiatry, which professional and disciplinary lines of demarcation have so far succeeded in keeping frozen (in the English-speaking world at least), must start with the prior questions of what kind of creatures people are, and how we should go about observing and accounting for their behaviour and misbehaviour.

It is suggested that the main reason the DMA is unable to assist us in understanding and alleviating psychological suffering is because it is underpinned with assumptions about human beings and their suffering which are inherently faulty.

The first, and perhaps the most essential, assumption underpinning the DMA is that certain activities and experiences of persons in the West (those referred to as 'mental' or 'psychological' and which are seen as occurring 'inside' the person, e.g., thoughts, beliefs, wishes, fears, hopes, etc.) are seen as representing or occurring in something called the 'mind', an entity posited to contain, or comprise, these activities and experiences. It is this mind that is considered to encapsulate or represent the person's uniqueness, or individuality. It is seen as private and personal, accessible only to its owner, and yet it is also seen as being open to the probings of science. It is generally accepted that the mind can be divided into various pieces or functions, and that these can then each be analysed and 'explained' separately from the other by an appropriately trained expert.

This reification of certain activities and experiences into an entity called 'mind', which can then be 'investigated' by science, has made it easy to conflate the metaphorical 'mind' with the brain. This leads to the reductionist position, taken by most bio-psychiatrists, that 'mind' is essentially brain and that by understanding how the brain works we will also understand how the mind works. This is seen by some

(refs) as a resolution to the 'mind-body' problem in psychology, and also makes possible the general acceptance of non-intentional explanations for intentional phenomena.

This view of human beings has contributed towards the notion that those forms of psychological suffering seen as 'mental illnesses' are grounded in biological factors. Genes, neurochemistry and neuroanatomy are often hypothesised to cause 'mental illness' while 'the environment' is often relegated to the role of a 'trigger' for a pre-existing genetic or otherwise biologically caused vulnerability to 'mental illness'. Due to this view the medicalisation of many forms of psychological suffering has been inevitable.

The notion that certain sorts of psychological suffering are indicative of a 'dysfunctional' or 'diseased' 'mind' (or brain) is, not surprisingly, another of the fundamental assumptions underlying the DMA. As has been noted earlier in this chapter, even for those even for those who do not conflate 'mind' with brain, psychological suffering is still conceptualised as representative of a 'dysfunction' or 'disorder', albeit of the metaphorical mind rather than the literal brain (Svensson, 1995), and thus seen as best dealt with within a medico-scientific framework.

The third general assumption underlying the DMA is that humans are autonomous individuals essentially separate from each other, and from 'society' and that society is simply a backdrop to human life. This can be seen clearly in psychology's, and psychiatry's, focus on the individual, and the search for causal processes 'inside' individuals, an approach which means that the environment within which individuals live out their lives tends to fade into the background. As Handy (1987, p. 162) notes of general psychology:

> [b]y failing to examine the interplay between social structure and individual subjectivity and concentrating on the analysis of the individual as a relatively isolated entity the discipline implicitly accepts and reinforces the cultural norms concerning individualism.

Psychology's (and psychiatry's) assumption that society is made up of autonomous individuals is usually accompanied by the further assumption that these individuals are operating within a relatively benign social order which provides adequate opportunities for people to develop their potentialities (Hall, 1983, cited in Handy, 1987). Because social structures are not seen as constraining, human behaviour is explained by internal, personal characteristics rather than by situations or relationships; thus failure is often seen as due to personal shortcomings or personal pathology. This leads to a failure to deal with the political and historical contexts of human behaviour, a charge that has been levelled against psychiatry (Elias, 1969; Ingleby, 1980; Pilgrim & Rogers, 1999), clinical psychology (Cromby, 2006; Pilgrim, 1992;

Pilgrim & Treacher, 1992; Schumaker, 2001; Smail, 1993; Treacher & Baruch, 1980) and general psychology (Cromby, 2006; Handy, 1987)[21].

The view of human beings as autonomous individuals who are essentially unaffected by their environment is reflected in the way in which most people in the West conceptualise themselves as "self contained unitary individuals who carry their uniqueness deep inside themselves, like pearls hidden in their shells" (Burkitt, 1991, p. 1), with "a distinct boundary that separates [them] from society and from nature" (Barrett, 1996, p. 180).

As Barrett (1996) points out, the individual in the West while conceptualised as unitary is also, simultaneously, conceptualised as an ensemble of parts. These parts are often thought of as divisions or dichotomies; for example body and mind, emotions and cognitions, rationality and irrationality, actions and thoughts. Scientific psychology has broken the human being up even more comprehensively, with the modular mind[22] favoured by many evolutionary psychologists representing the apex of this approach (Karmiloff-Smith, 2000).

As Barrett (1996, p. 181) describes, these divisions are also reflected in scientific and popular ideas about heredity in which a person is seen as a "composite of nature and nurture, or a combination of characteristics inherited from maternal and paternal genes". Barrett (1996, p. 182) goes on to note that

> [w]hen put together, the individual and the ensemble form a concept of the person as a tension between whole and parts. A spatial metaphor is evoked, as if the person could be represented by a circle or a sphere, with a clearly demarcated external boundary and an interior that can be divided into sections.

It is suggested that the view of human beings presumed by these underlying assumptions is not an accurate one, and that because of this the DMA will never be able to resolve the theoretical and practical difficulties discussed in this chapter. It is further suggested that in order to move beyond the conceptual confusion and practical deficiencies of the DMA and towards an alternative conceptualisation of psychological suffering it is necessary to challenge these underlying assumptions and to explore alternative ways of understanding what it is to be a person.

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[21] It should be noted, of course, that this generalisation applies to the disciplines overall rather than to individual academics and practitioners within these disciplines.

[22] This is the claim that evolution has resulted in our brains becoming increasingly 'prespecified' into a number of domains or modules. Each module is suggested to specialise in a particular function, including the higher-level cognitive functions such as language acquisition and use, numeracy skills, face recognition and etc. Steven Pinker's (1997) *How the Mind Works* is perhaps the best example of this, its key idea being that "the mind is a system of organs of computations, designed by natural selection to solve the kinds of problems our ancestors faced in their foraging way of life". According to Pinker (1997) the mind is organised into modules that are 'designed' to be 'expert' in one particular area.

In the following chapter I will outline an approach to the study of human experience that overturns these assumptions, and in so doing overturns the notion of the "atomistic, bounded, coherent, rational psychological subject endorsed, at least implicitly, by most mainstream approaches"(Cromby, 2004, p. 797). In the remaining chapters of this thesis I will then attempt to sketch out the beginnings of an approach to understanding psychological suffering based upon this 'alternative view' of human beings – an approach which acknowledges the personal and embodied reality of such suffering but does not attempt to locate its genesis, or its course, purely within the individual.

While this alternative approach will, of necessity, acknowledge the realities of the various levels of our being in this world – the biological, the 'psychological' and the social – in order to reach a better understanding of psychological suffering, it will, nevertheless be more than just another 'biopsychosocial' account. As has been noted above, the biopsychosocial approach to psychological suffering is really no more than an attempt to 'patch together' the two opposing accounts which have dominated psychiatry since its beginnings – the somaticist and the metaphorist accounts. The assumptions about human beings that underlie the newer biopsychosocial accounts, however, remain exactly the same as those which underlie the accounts they seek to replace and thus they are unable to offer any radically new understandings of psychological suffering.

Such accounts still see the human being as being essentially a composite of parts that are separable by science, as outlined above – the 'mind' and the body, emotions and cognitions, rationality and irrationality, actions and thoughts. Such accounts also see the human being as separable from the social and material environment with the environment merely 'impacting upon' people in various ways, or, in the case of 'mental disorders', 'triggering' vulnerabilities that are internal to the person.

Furthermore, such accounts still view the 'psychological' aspect of human beings as being contained in, or represented by, an entity referred to as the 'mind' (which may or may not be conflated with the brain, depending on the account), and this 'mind' (or brain) generates various 'mental' or psychological phenomena such as thoughts, desires, obsessions, hallucinations and etc. It is this 'mind' which 'dysfunctions' and 'causes' the person to feel/think/act in ways which are considered to be 'ununderstandable[23]', in which case they are said to be suffering from a 'mental disorder'.

[23] As was noted in Chapter One, this is a term coined by Karl Jaspers (1963, cited in Sass, 2002) a German phenomenological psychiatrist, to describe the kinds of 'psychopathology' that were "closed to

Such feelings/thoughts/actions are so 'extreme', as Wakefield (1992a, p. 243) notes, in his attempt to pin down the concept of 'mental disorder' once and for all, that "nothing but the breakdown of internal mechanisms could be expected to cause them". They are so 'extreme' that they could not possibly be a "natural response that is initiated and maintained by the ongoing stress" (Wakefield, 1992a, p238) and nor could they be a "normal, proportionate reaction to an unusual environmental stressor" (Wakefield, 1997a, p. 646).

In the analysis to follow it will be suggested that the feelings/thoughts/actions which are 'symptomatic' of the various 'mental disorders' listed in the DSM-IV-TR (American Psychiatric Association, 2000) are, in fact, completely understandable if they are seen as being emergent from our continual enmeshment within our social world, rather than as arising primarily out of the various processes occurring within us (whether that be our neurochemistry or our 'mental mechanisms' or an 'interaction' between them).

As soon as the human being is fully contextualised, and the person and their person-level experiences, rather than their neurochemistry or their 'mental mechanisms', are placed centre stage, the mist starts to clear and one can start to start to explore the ways in which such suffering may arise. The insights gained from a clearer understanding of the genesis of such suffering could then be used to move towards not only new ways of alleviating or even preventing such suffering, but also towards new understandings of why the feelings and behaviours considered 'symptomatic' of 'mental disorder' or 'mental illness' are actually experienced as 'suffering', rather than as just another way of being in the world.

In the final two chapters of this thesis I will sketch out an example of how such a 'person-based' exploration of psychological suffering could be carried out. This exploration will focus on the foundational nature of people's relationships with their first care-giver and attempt to illustrate how the origins of the vulnerabilities for experiencing the 'clusters of suffering' conceptualised as 'mental illness' or 'mental disorder' can emerge from the same source as all other aspects of our personal being; from the constant coactions between the various aspects of our being in the world – personal, organismic and molecular – with the environment within which we are enmeshed. It is, of course, acknowledged, that this approach represents only one of

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psychological comprehension" (Sass, 2002, p. 251). Such suffering, in other words, was so bizarre it could only be caused by 'dysfunctions' or aberrations of the 'mind' or brain.

many ways in which psychological suffering could be usefully explored utilising the alternative conceptualisation of persons to be offered in Chapter Three.

This means that the feelings/thoughts/behaviours which are conceptualised as 'mental disorder' are as much part of our personal being as any other aspect of us, they are not 'other', they are not 'disease', 'illness' or 'dysfunction'. Indeed, as will be illustrated in the final two chapters, such feelings/thoughts/behaviours almost always represent a very adaptive response, at every level of our being, to environmental contingencies. Thus, it is suggested that when understood in its full context, the suffering conceptualised as 'mental illness'/'mental disorder' can be seen as the very understandable responses of the human person to what is happening to them, rather than 'un-understandable' dysfunctions, aberrations and pathological processes of the 'mind' (or brain).

CHAPTER THREE

THE SOCIAL CONSTRUCTION OF PERSONS AND THEIR SELVES

3.1. INTRODUCTION

> Children 'inherit' their humanity . . . in a process of communication which takes place after birth . . . What has been overlooked in modern psychology . . . is that man is not simply a being immersed directly in nature but is a being *in a culture* in nature.
> (Shotter, 1975, cited in Shotter, 1993b, pp. xii-xii, italics in original)

In Chapter Two it was argued that the current dominant account of psychological suffering in Anglo-American societies, the Dysfunctional Mind Account (DMA), is not adequate to the task of explaining or understanding such suffering. It was suggested that one of the primary reasons for this is because the DMA is underpinned with assumptions about human beings and their suffering which are inherently faulty. It is suggested that the view of human beings presumed by these underlying assumptions is not an accurate one, and that because of this the DMA will never be able to resolve the theoretical and practical difficulties discussed in Chapter Two. It is further suggested that in order to move beyond the conceptual confusion and practical deficiencies of the DMA and towards an alternative conceptualisation of psychological suffering it is necessary to challenge these underlying assumptions and to explore alternative ways of understanding what it is to be a person.

There are a number of theorists within the social sciences who have questioned these assumptions (e.g., Edwards & Potter, 1992; Elias, 1982; Gergen, 1984; Harré, 1998; Shotter, 1984; Shweder, 1991; Vygotsky, 1978). These theorists have essentially attempted to repair the fundamental split between the individual and his/her environment that pervades many of the social sciences (including psychology, psychiatry, sociology and anthropology) by showing that each is essentially constitutive of the other.

As Armon-Jones (1986, p. 32) notes, the notion that individual experience is socio-culturally constituted "originated in the critical positivist tradition of post-

enlightenment social philosophy". George Herbert Mead (see Mead, 1956), an early exponent of this view, saw the behaviour and experience of individuals as constituted by, rather than prior to, the social group of which the individual is part. Mead's work was influential in promoting studies of the interdependence between the social world and the shaping of individual behaviour and experience. This approach to theorising about human beings is often referred to by the umbrella term 'social constructionism'[1].

As Handy (1987, pp. 163-64) points out, while there are considerable differences in emphasis between those theorists who are characterised as 'social constructionist' one of the most fundamental propositions of the approach is

> that human subjectivity and action are so inextricably interwoven with the social context which people inhabit that a theoretical separation between the individual and society is conceptually inadequate . . . This necessitates developing analyses which acknowledge firstly, that human subjectivity and actions are constituted within and through social structures, and, secondly, that people are also the producers of the social structures they inhabit.

Cromby (2004, p. 797) suggests that perhaps the most substantive commonality within the "diverse assemblage" of "philosophy, theory and research" which is referred to by the term of 'social constructionism' is "the rejection of the Cartesian subject of mainstream psychology". Cromby (2004, p. 797) points out that

> [a]longside a focus on language and a view of society as the prime mover, the guarantor of knowledge and root of experience, constructionist psychology rejects the atomistic, bounded, coherent, rational psychological subject endorsed, at least implicitly, by most mainstream approaches. Instead, constructionists observe that notions of the person are culturally obtained and promulgated . . . and proposed that thought has a discursive, argumentative or dialogical character that utilizes the 'common sense' themes and dilemmas of a culture.

As has been noted above, the Dysfunctional Mind Account of psychological suffering presupposes a 'mind' which can become, even if only metaphorically, 'ill' or 'disordered'. For social constructionists, however, there is no such entity. For social constructionists the mind is neither the receptacle for, nor the originator of, our thoughts or any of our other 'mental' states. Indeed, one of the basic premises of a social constructionist approach to psychology is that those processes commonly conceptualised as 'mind' are primarily public and collective and are located

[1] The term 'social constructionism' is often somewhat 'over-extended' and certainly not all of the above-mentioned theorists would consider themselves to be 'social constructionists'. I will use the term here, however, as the signifier for the general approach outlined above in the absence of any more appropriate term.

> in the contingent, unbroken responsive flow of language intertwined interaction between people as they spontaneously cope with each other in different circumstances.
>
> (Shotter, 1997, p. 9)

Indeed, according to Harré (1998, p. 49), mind

> is created by people *ad hoc* in the activities of everyday life, including private acts of thinking as well as public and collective cognitive performances. Mind is nothing but meaningful action.

I will now turn specifically to the work of the two social constructionist theorists just quoted above, John Shotter and Rom Harré[2], who offer a way of viewing human psychology which radically challenges all of the assumptions underlying the DMA. Both these theorists acknowledge the impossibility of attempting to separate the individual from their social world (proximal and distal) and argue that human subjectivity and actions are constituted within and through the immersion of the individual in that social world.

The work of these theorists is particularly useful within the context of this thesis because of their focus on understanding the social construction of our subjectivity, our experience of being persons in the world, what Rom Harré (1984a) refers to as our 'personal being'. For Harré (1984a) this 'personal being' encompasses (a) one's sense of oneself as a singular being with a continuous and unique history (b) one's capacity for self-reference ('self' consciousness), and (c) one's sense of oneself as an agent – "a being in possession of an ultimate power of decision and action" (Harré, 1984a, p. 29). Our personal being[3], in other words, comprises our various 'senses of self', as will be outlined further in section 3.1.3.

As Shotter (1984, p. 49) points out, in order to become a 'person' "the provision of the appropriate initial ecological conditions is vital" and "so is the participation of another person in the process". As Shotter (1984, p. 49) goes on to note

> [o]nly by attending closely to another's spontaneous actions, and selecting socially relevant aspects of them, can [a human being] construct a socially accountable ideal self, an image of genuine personal being, which can be held out to the other as a challenge to

[2] The approaches taken to human psychology by these two theorists are by no means identical but heir approaches to understanding the process of the social construction of human experience are, however, broadly consistent and, as Morss (1996, p. 44) points out, "they share many commitments and values, and . . . agree on many points of criticism of orthodox psychology".

[3] I will use this term to refer to the psychological experience of being a 'person' because it more thoroughly encompasses the various aspects of our being in the world than more commonly used terms such as 'personality', or 'self'. The sense of experiencing oneself as a 'self', however, is, according to Harré (1998) a central aspect of our personal being, and thus will be central to the alternative account of psychological suffering developed in this thesis.

> be attained; one person can help another to become more of a person. By instruction[4] individuals can become responsible themselves for actions which initially arose in the context of their interaction with others.

If Harré and Shotter are correct and what Harré (1984a) refers to as our 'personal being' emerges from our enmeshment with our social world, then it is likely that the kinds of suffering conceptualised as 'mental illness' may also emerge, at least in part, from that enmeshment. Thus, if we could understand the processes involved in the emergence[5] of our 'personal being' it is possible we may be able to come closer to some understanding of why the various problems we call 'mental illness' occur and begin to move towards a way of conceptualising such suffering that does not frame such experiences as 'illness' or 'dysfunction' but, rather, sees them as emerging from the intricate coactions between the person and the social world within which they must live their lives.

3.1.1. Conversation without end: The social constructionism of John Shotter and Rom Harré

Harré (1984a, p. 20) suggests that there are "two primary realities in human life: the array of persons and the network of their symbiotic interactions, the most important of which is talk". Harré (1984a) suggests that thought represents the privatization and personalization of part of that network. For Harré (1984a) these two realities, persons and their interactions, can not be reduced one to the other, but each is necessary if the other is to exist. For Harré (1984a; 1998), and for Shotter (1993a; 1997), the concept of the 'person' – "the embodied, publicly identifiable and individuatable and unanalysable being around which the human form of life revolves" (Harré, 1998, p. 177) – and the 'joint actions' of those persons should form "the ontological basis of all psychology" (1992, p. 154).

Thus, for Harré (1984a, p. 20), as for Shotter,

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[4] And in most cases this 'instruction' is provided 'naturally', without conscious intention, within the context of everyday interactions.

[5] The word 'emergence' is a dynamic systems term that refers to "spontaneously generated (i.e., emergent) order in complex, adaptive systems (Granic & Hollenstein, 2003, p. 644). See Chapter Five for a discussion of the usefulness of a dynamic systems 'heuristic' in attempting to build an understanding of persons and their suffering which acknowledges all of our various aspects of being in the world – the molecular, the organismic, and the personal and how they coact with the social world within which we are enmeshed.

> The fundamental human reality is a conversation[6], effectively without beginning or end, to which, from time to time, individuals may make contributions. All that is personal in our mental and emotional lives is individually appropriated from the conversation going on around us and perhaps idiosyncratically transformed. The structure of our thinking and feeling will reflect, in various ways, the form and content of that conversation.
>
> (Harré, 1990, p. 341)

Shotter (1993a, p. 7) suggests that it is within this "contingent flow of continuous communicative interaction between human beings", a sphere of activity he refers to as 'joint action', that "all the other socially significant dimensions of interpersonal interaction, with their associated modes of subjective or objective being, originate and are formed" (Shotter, 1993a, p. 7).

As Harré (1998, p. 50) notes

> [s]ocial life is not an *ad hoc* coming together of individuals, hazardously trading hypotheses as to what each one is thinking and doing. The minds of individuals are privatized practices condensing like fog out of the public conversation onto material nuclei, their bodies.

In line with this insight, Harré (1984b, p. 128) suggests we suspend our "usual practice of looking inside [ourselves] and other people for the primary places of thoughts" and notes that "many mental phenomena . . . have their primary place in public displays". For Harré (1984b, p. 128) "emotions are just as much displayed as felt, while promises, if kept to oneself, mean nothing". Harré (1984b, p. 128) suggests that our 'mental' activities, such as "reasoning, declining, making commitments, and even feeling" are essentially located within the conversations in which we engage. This does not mean, however, that these 'mental' activities are not central to our subjective sense of being in the world, nor does it mean that they are 'disembodied'. When we reason, decline, make a commitment and feel an emotion our bodies are engaged in these activities too, as will be discussed in more detail in Section 3.3.

Indeed, Shotter (1993b, p. 107) suggests that rather than being as logical or systematic as psychologists and philosophers have often assumed, our 'minds'

> reflect in their functioning essentially the same ethical and rhetorical considerations influencing the transactions between people, out in the world. And furthermore, rather than being organised at the centre of our being (thus to be given orderly expression or not as required), they are organized peripherally, in a moment-by-moment process of 'ethically sensitive negotiations' at the boundaries of our being, where the negotiations involved are as varied in their form, say as those between intimate lovers, parent and

[6] The word 'conversation' is used here in the extended sense and includes those 'extra-discursive' aspects of our interactions with each other such as gestures and facial expressions and also includes our 'conversations' with ourselves.

> child, those between distant strangers, those between poets and logicians, or those between different social classes.

Thus, for Shotter and Harré our individual, unique mental lives are essentially social productions. Indeed, Harré (1984a) characterises them as being the result of the acquisition of a theory rather than of biological maturation and suggests that most of the things we take to be "metaphysically ultimate in psychology are referents of theoretical concepts" (1984a, p. 21). As Harré (1984a, p. 20) notes,

> [a] person is not a natural object, but a cultural artefact. A person is a being who has learned a theory, in terms of which his or her experience is ordered.

Both Harré (1984a, 1998) and Shotter (1974a; 1974b; 1984; 1997) suggest that this 'theory learning' process occurs within the context of an infants' earliest social relationships, and in particular their relationship with their mother[7]. As Harré (1984a, pp. 21-22) notes, from the very beginning "infants make demands upon their mothers and other caretakers that provoke the very talk and action from the mother" that facilitates the development of personal being – a being with a sense of oneself as a singular being with a continuous and unique history with a capacity for self-reference ('self' consciousness), and a sense of oneself as an agent – "a being in possession of an ultimate power of decision and action" (Harré, 1984a, p. 29).

As Harré (1984a, p. 22) points out, and as will be detailed in Section 3.2,

> each level of sophistication of public –collective activity in which a developing person joins is perpared for, not by a maturing natural endowment, but by the previous level of that interpersonal, public and collective activity.

Thus, what seem to be the child's 'natural' contributions to this process have already emerged, suggests Harré (1984a, p. 22), from the "personalization of the social structure" within which the child's personhood is being established.

From the viewpoint of the kind of social constructionism espoused by these two theorists, everything that is taken to a 'real psychology object' in the cognitive (realist) account – things like our intentions, memories, motives, perceptions, emotions, etc. – can be talked of in a different way: Such psychological phenomena are not already finished and finalized entities, rather, they are still in the process of construction. This means that at all times in a person's life they are both partially constructed and, also, open to further

[7] It is acknowledged that some children have primary caregivers who are not their biological mothers (for e.g., grandmothers, aunts, adopted mothers, fathers, etc.). When the word 'mother' is used it is shorthand for primary caregivers of all kinds.

construction, or even, re-construction, in different ways and in different circumstances, according to the person's sense of how they are placed in relation to both their own project and to the other people around them (Shotter, 1997).

Indeed, Shotter (1997) claims that it is "only through the semiotic mediation of signs, within an inner conversational process, that what we talk of as our 'self', our 'psyche', or our 'mind', comes into existence at all, but that . . . 'minds', 'selves', or 'psyches' exist as such, only within our embodied discursive practices". In accordance with this, Harré (1984a, p. 21) suggests that by adopting 'theories' in which concepts like 'mind' and 'self' have a place, "we so structure our experience as to create them: different theories, different mental organization". Because of this, while our 'minds' and our 'selves' may not be actual entities these 'theories' nevertheless exert a very real influence over our lives and the way we live them.

As Shotter (1993a, p. 22) argues, when we talk of our 'minds' this leads us to talk as if our 'minds' exist as the real things underlying our behaviour. This allows us, suggests Shotter (1993a, p. 31) to

> structure and manage our individualistic forms of life, and to create certain forms of social institutions, not available to those those lacking such a 'language of the mind'. This, indeed, is the nature of our 'social reality'; we sustain and manage it through such forms of talk.

Through such talk, Shotter (1993a, p. 31) maintains,

> people are not making a *reference* to the nature of their already existing minds, but are taking part in a contested (or at least contestable) process, a tradition of argumentation, in which they are still struggling over the constitution of their own mental make-up. At a personal level, the whole lexicon of 'mind' and 'mental activity' terms provides a set of rhetorical resources or devices for use by them to serve their own personal interests in that struggle; while at a social level, it is a way of talking that serves to sustain and perhaps develop further, our own Western form of social life and personhood.

As Shotter (1984) notes, by taking viewing 'minds' and all the other 'mental entities' we have created through this lens we can begin to repudiate

> the 'Cartesian starting point' – localized in the 'I' of the individual . . . and replace it within a more diffuse and flowing process – a process with not only social, cultural and historical aspects to it, but with biological and ecological ones too; a large-scale developmental process which is productive of individual, localized subjectivities, but which itself is, as Popper (1972, cited in Shotter, 1984) puts it, 'without a knowing subject'.

Both Harré and Shotter (in common with a number of other social constructionists, including John Cromby, whose work I will be discussing later in this

chapter) draw on the work of Russian developmental psychologist Lev Vygotsky in order to explain how 'natural powers' are transformed, via social interactions with significant others, into 'personal' or 'acquired powers'. As Tissaw (2000, p. 847) puts it, in Vygotsky's account

> [t]he immediate social surroundings of infants and young children constitute the framework within which innate, prelinguistic individual powers become the differentiated powers of thought and action recognised by care-givers as psychological growth and maturity.

As both Harré (1998) and Shotter (1984) point out, it is via the processes identified by Vygotsky's research that an infant's perception of arrays of things in the world is transformed into an adult perception of person-centred external and internal environments, action becomes agency, dependency becomes respect and memory becomes autobiography. Vygotsky's insights are so central to the social constructionist account of persons and emergence being outlined in this thesis that before proceeding any further it is necessary to provide some background on Vygotsky's "strange and surprising psychology" (Shotter, 1993b, p. 108).

3.1.2. Vygotsky: A brief introduction

The research of Lev Vygotsky (1896-1934), a developmental psychologist working in Russian during the early twentieth century, was carried out within a tradition commonly known as cultural-historical psychology. According to Cole (Date Unknown, p. 2) cultural-historical psychology

> begins from the assumption that there is an intimate connection between the special environment that human beings inhabit and the fundamental, distinguishing, qualities of human psychological processes. The special quality of the human environment is that it is suffused with the achievements of prior generations in reified (and to this extent materialized) form.

As Cole (Date Unknown, p. 2) points out, for cultural-historical psychologists like Vygotsky

> the development of the mind is the interweaving of biological development of the human body and the appropriation of the cultural/ideal/material heritage which exists in the present to coordinate people with each other and the physical world.

For Vygotsky, our 'minds' emerge from our active engagement with our environment, they are not in existence prior to the commencement of that engagement.

As Vygotsky notes, "the social dimension of consciousness is primary in time and in fact. The individual dimension of consciousness is derivative and secondary" (Vygotsky, 1979, p. 30 , cited in Wertsch, 1985, p. 58). [8]

As Burkitt (1991, p. 145) points out

> Vygotsky's entire corpus of works aims to show that the relation between the child and its environment does not unfold spontaneously from the child's own activity considered in isolation from others. Rather, the child must always be considered in an interdependent relation to those around him or her, who instruct the child in its activities using the materials and knowledge of the day.

For Vygotsky, psychological development occurs within the relations between the child and its environment, particularly its social environment. Vygotsky's approach, as Burkitt (1991, p. 144) points out, is a dialectical and developmental one, and thus the child's psychological development is seen as occurring *within* the relations between the child and its environment, "not externally to them". It is not a case of the child being on one side and the environment being on the other. The child's 'personal being' is

> constituted in its active relationship to the world. It is this relationship that will become internal to the child and shape the psychological plane and the structure of the self.
> (Burkitt, 1991)

According to Vygotsky (1978) the higher cognitive capacities, such as language and the ability to think about oneself (fundamental to the notion of possessing a unique individual 'self with an 'inner life'), are developed during the course of our interactions with others. These formative interactions occur when the infant attempts or seems to attempt a task, either manipulative or cognitive, and an older, more skilled, person (usually an adult but sometimes an older child) will supplement its efforts in such a way as to complete the task.

At this stage the cognitive or motor skill is, as Vygotsky (1962) puts it, 'in the zone of proximal development[9]". Development has occurred when the child can do for itself the supplementing action offered by the parent or older child. The child can then complete the task him or herself. In other words the child must master tasks "practically, in its interactions with adults, before it masters them intellectually and can use them autonomously" (Burkitt, 1991, p. 147).

As Vygotsky (1962, pp. 90-91) notes,

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[8] As Wertsch (1985, p. 67) points out, this resonates with Mead's (1934, cited in Wertsch, 1985, p. 59) claim that "the social act is a precondition of [consciousness]".

[9] The 'zone of proximal development' is essentially the range of potential each person has for learning – with what the person can do without assistance at one end, and what s/he can do with assistance at the other.

> consciousness and control appear only at a late stage in the development of a function, after it has been used and practiced unconsciously and spontaneously. In order to subject a function to intellectual control, we must first possess it.

This is not to say that Vygotsky denied the importance of biology in determining what skills a developing child can begin to acquire at various points in its life, but he did not believe that biology *leads* the process of psychological development. Rather, for Vygotsky, it is cultural instruction "which determines the level to which people will develop psychologically"[10] (Burkitt, 1991, p. 146) and it is speech which plays the key role in the transmission of this instruction.

As Burkitt (1991) points out, Vygotsky's own empirical research suggested that there were three stages in the development of speech and thought in a child. Firstly there is 'social speech' when the child is "introduced to the speech content of the adult world" by its parents and other adults and older children. Then comes 'egocentric speech' in which the child uses words "to guide its own behaviour by talking aloud to itself as an adult would who was giving the child instructions" (Burkitt, 1991, p. 147). The third stage of this development is 'inner speech'. At this stage the child no longer speaks out loud to itself, but rather speaks 'silently' to itself – "having internalized the social form of communication as a way of autonomously regulating its own actions" (Burkitt, 1991, p. 147). As Burkitt (1991, p. 147) notes, "at this stage speech 'centres' itself in the personality as a conscious ego – the 'I' – which creates the internal plane of self-consciousness".

For Vygotsky, then, psychological functions develop on the social level, within relationships between humans, before they develop at the psychological level. This is expressed in Vygotsky's (1966, p. 44, cited in Shotter, 1993b) 'general genetic law of development' that

> [a]ny function of the child's cultural development appears on the stage twice, on two planes, first on the social plane and then on the psychological, first among people as an intermental category and then within the child as an intramental category.

As Shotter (1993b, p. 111) notes this essentially means that "within the child, the same ethical concerns which are held in the social realm are still of importance in the 'inner' psychological realm of the individual". Shotter (1993b, p. 112) further notes that when a function appears 'within' the child – via a process Vygotsky calls 'internalization' – this does not mean there has been a spatial or geographical

[10] This 'rule' would not apply, however, if a child were brain damaged in any way.

transformation, but rather a "transformation in our responsibility for things". Shotter (Shotter, 1993b, p. 112) stresses that Vygotsky is not talking about a process

> whereby what was in the adult's head gets transferred into the child's head, he is talking about a process in which things which at first a child only does spontaneously and unselfconsciously, under the control of an adult, comes under the control of the child's own personal agency.

Thus, as Lock (1981, p. 29) notes, there is in development "a transfer of the control of action from one individual to another". Lock (1981) further notes that this transfer occurs through the development of symbolization, particularly in the form of language. This results, according to Lock (1981, p. 30) in the child becoming

> able to control processes that he previously could not by an 'internalization': his individual construction of the symbolizing other.

As Burkitt (1991) notes, before a child begins to master speech its thinking is tied to its practical activities and its socio-emotional attachment to its mother. The child's relationship with its mother forms the milieu where "needs can be expressed and met, and . . . wishes and desires are created" (Burkitt, 1991, p. 147). As Burkitt (1991, p. 147) goes on to point out

> [a]t this stage in development, thinking is totally encapsulated in the child's activity and emotional responses, and has not yet developed as self-consciousness which can regulate and direct actions.

According to Vygotsky (1962, p. 150), this level of mental functioning never disappears because

> [t]hought itself is engendered by motivation, i.e., by our desires and needs, our interests and emotions. Behind every thought there is an affective-volitional tendency, which holds the answer to the last 'why' in the analysis of thinking. [11]

As Burkitt (1991, p. 148) points out while this 'pre-verbal' level of mental functioning never disappears "what is transformed . . . as children begin to master language, is the actual thought processes themselves". While emotion and desire may

[11] This seems to conflict with the position held by Shotter and Harré (see p. 19 above) that our motives are the product of our activities rather than our activities being the product of our motives. Upon closer examination though the "affective-volitional tendency" which is "behind every thought" is still essentially generated by the child's activity and emotional responses, as Harré and Shotter would suggest. The "emotional responses", however, while themselves heavily influenced by a child's experiences and activities in the world are also going to be influenced by the child's biology, which itself, of course, will itself be influenced by the child's activities and emotional responses. As will be discussed in more detail in Chapters Five and Six, social and biological factors interact in various directions resulting in complex feedback loops which can precipitate, exacerbate and alleviate psychological suffering.

remain the motivational forces behind thought, language enables thoughts to "find a new medium for formulating themselves and a totally new structure" (Burkitt, 1991, p. 148). This, in turn, leads to transformations, via language, of the original motivational force – it being strengthened, weakened, or entirely changed by the way in which we tell stories about it to ourselves and others.

Thus, for Vygotsky (1987, p. 251, cited in Burkitt, 1999, p. 148)

> speech does not merely serve as the expression of developed thought. Thought is restructured as it is transformed into speech. It is not expressed but completed in the word.

Vygotsky's empirical work suggested that the development of thought and speech are separate until the child is about two years old (Burkitt, 1991). At this stage, according to Vygotsky, thought and speech combined to initiate new forms of thinking and acting. The child, in discovering the signs which represent objects in the world, discovers the symbolic function of words and learns to place objects, including itself, "in a system of social meanings, and . . . thereby [becomes] an object to itself" (Burkitt, 1991, p. 148).

This insight is supported by research carried out by Bozhovich (1979, 1980, cited in Burkitt, 1991, p. 150) which has shown how, at about the age of three years, the child begins to recognize itself as the subject or initiator of its own acts. As Burkitt (1991, p. 148) notes, "it is at this juncture the self begins to emerge in awareness and the inner conversation is begun with the self [and] . . . self consciousness is being forged out of the consciousness of experience within communicative interaction".

As Burkitt (1991, p. 149) goes on to point out, Vygotsky's work suggests that "consciousness develops within the personality as a whole – in its bodily, emotional/volitional aspects". With each stage of the development of consciousness there is a transformation in its structure. To begin with, mental activity remains on the level of 'practical consciousness' (Giddens, 1984, cited in Burkitt, 1991, p. 149), where there is a non-reflective understanding of how to perform an action. Late, however, as thought and speech begin to merge, 'discursive consciousness' (Giddens, 1984, cited in Burkitt, 1991, p. 149) appears. At this stage thoughts can be put into words – for other people and for oneself – and there is self-conscious awareness and control over thought and action. [12]

[12] As will be discussed in Section 3.3, however, this self-conscious awareness and control over thought and action is never total.

Burkitt (1991, p. 150) suggests that at this point "involuntary motivation no longer remains the driving force in the personality, as the cognitive and affective processes are brought into balance by the self-conscious personality – the 'I'". The 'I' is, as Harré (1998) makes clear, itself a product of speech, and becomes "the linguistic reference point that the child uses to identify its new found sense of its own self as a subject and initiator or action" (Burkitt, 1991, p. 150). As Tissaw (2000, p. 847), citing Bruner (1984), points out, "the primary responsibility for this transformation is not the child's but depends 'on society's capacity to provide the child with the symbolic tools that the child need[s] in order to grow" (Bruner, 1984, p. 96, cited in Tissaw, 2000).

As has already been noted above, one of the fundamental insights drawn by social constructionist theorists from Vygotsky's work is that our 'inner lives' (our 'thoughts', our 'personalities' our 'mental states', our very 'minds') are 'appropriated' from the 'general conversation' (in the extended sense) going on around us. As has also already been noted above, if this insight is correct, then our psychological suffering, too, must emerge from the 'conversation' within which we are all embedded and engaged. Thus, it is to this conversation, the social interactions within which the child is embedded, that we must turn if we wish to move towards a better understanding of such suffering.

As was pointed out above, Shotter (1984) suggests that children derive their personal powers from their pre-existing 'natural' powers. As has already been noted, this is not something they can do on their own; such a process requires the help of someone who already possesses such 'personal powers' someone who is, ideally, in a '*love*-relation' to the child, "someone who cares sufficiently to reflect them back to themselves in an ideal way, i.e., in a way which indicates to them which of all the things 'they' do are the things highly valued in their society" (Shotter, 1984, p. 56, abbreviation in the original). This is usually, but not always, the biological mother. Thus, Shotter (1984, p. 56) suggests that in order to understand how children are "transformed from almost wholly 'natural' agents' into individual personalities" it is necessary to attempt to understand "what goes on between and within mothers and their children" during the early stages of development.

For both Harré (1998) and Shotter the transformational processes which occur between a mother and her child take place primarily during a period some theorists have called 'psychological symbiosis' (Newson & Shotter, 1974; Spitz, 1965) – a stage beginning with the first smile and ending when the child's use of language becomes sophisticated enough to enable them to engage in private discourse and carry out

complex cognitive acts for themselves. Within this symbiotic relationship, according to Harré (1984a, p. 105), "certain kinds of language games[13] are played, engendering talk with appropriate cognitive properties, for instance self-expression of feelings and intentions"[14], language games essential to the emergence of our sense of being a 'self'; a unique individual with agentic powers and a personal life trajectory which we can own as our own and tell stories about, both to ourselves and to others.

Before going on to outline how our 'sense of 'self' emerges from within this symbiotic relationship, however, the way in which the 'self' is conceptualised in this thesis needs to be made very clear. As Falmagne (2004, p. 831) points out the notion of the 'self' has been the subject of rigorous poststructuralist critique in recent years. This critique has "subverted the traditional notion of a unified, bounded, stable, transparent self who is the origin of his or her actions and of social life". While there is much to criticise in this notion of the 'self', however, Falmagne (2004, p. 831) suggests, in line with social constructionist theorists, that

> the impulse that has fuelled the radical rejection of the 'self' and the shift toward a non-substantial, fluid notion of subjectivity in postmodern theorizing has been precipitous in assuming a necessary link between the notion of a substantial 'self' (which, as noted above, has been also been criticised by social constructionist theorists) and the unified, bounded, stable Cartesian self.

We can still continue to utilise the concept of the 'self', suggests Falmagne (2004), if the "self whose subjectivity we theorize can be complex, unstable, contradictory and contingently shifting while remaining substantial". Indeed it is just such a conceptualisation of self that can be found in Harré's (1998) social constructionist analysis of the 'self' which I will outline below. I will also, in the following discussion make some links between Harre's (1998) account of the 'self' and the account developed by Russell Meares' (2000), as presented in his book *Intimacy and alienation: Memory, trauma and personal being*. While Meares (2000) would not identify himself as a 'social constructionist', aspects of his work have strong resonances with the approach taken by Shotter, Harré and Cromby (whose work will be discussed later in this chapter). Meares'

[13] Language games (Wittgenstein, 1953) are essentially the enactment of language in the everyday activities of people, their 'forms of life'.

[14] It should be noted that this early pre-linguistic stage of development was not the focus of Vygotsky's research, and indeed in many of his writings he appears to claim that the 'mental functions' children are capable of at that age are automatic and innate within the personality. As Burkitt (1991, p 152) points out, however, there is "now evidence to suggest that children actively begin to appropriate the social heritage, and to construct their personality under the influence of their culture, before they have acquired linguistic competence". While this early pre-linguistic stage of development was not the focus of Vygotsky's work the findings to be discussed below nevertheless "complement his work and extend the spirit of his enquiries to the pre-linguistic stage of childhood" (Burkitt, 1991, p. 152).

(2000) insights are particularly useful with respect to understanding how the emergence of 'personal being', and the sense of 'self', may be affected by neglect and trauma during the early years of a person's life.

3.1.3. The self: One point of view, many aspects

As Sass (2007, p. 399) notes, along with notions of the 'individual' and the 'person', the notion of the 'self' is "amongst the most foundational and irreducible". Indeed, Harré (1984a, p. 26) suggests that the notion of 'self' should be the "central constructing concept of individual human psychology". As Harré (1998, p. 2) further notes, "it is uniqueness, personal singularity, that is the leitmotif of all our forms of life[15]" and this uniqueness and singularity is most often expressed and discussed by the use of the word 'self'. Further, and most importantly within the context of this thesis, the sense that this 'self' has somehow been disrupted, damaged, devalued, split, lost, or never formed at all is central to those experiences commonly conceptualised as 'mental disorders' (Cermolacce, Naudin, & Parnas, 2007; Crowley Jack, 1991; Estroff, 1989; Karp, 1996; Stone, 2004).

As Harré (1998, p. 1) points out, however, the notion of the 'self' is "not a clear, univocal or straightforward" one and suggests that a social constructionist / discursive approach to the concept of the 'self' may help to "abstract a modicum of order from . . . the flood of writing" on this topic. To this end Harré (1998) offers an alternative explanatory framework to that which underlies most 'mainstream' psychological accounts (including the various permutations of the Dysfunctional Mind Account) for understanding the self and its emergence.

As Harré (1998, p. 4) points out, in the Cartesian tradition (as exemplified by mainstream psychology and the Dysfunctional Mind Account) the sense of self has been interpreted to be "an intimation an entity has of its own existence". That entity, notes Harré (1998, p. 4) "has been variously categorized and located by generations of philosophers". For Harré (1998, p. 2), as for other social constructionists and discursive theorists, however

[15] This comment may be more applicable to Western, industrialised societies than to other less individualistic cultures. Indeed, Harré's analysis of the concept of 'self' applies primarily to our Western 'sense of self'. Other cultures, as Harré (1998) acknowledges, will be very likely to have other ways of being in the world.

> the self, as the singularity we each feel ourselves to be, is not an entity. Rather it is a site, a site from which a person perceives the world and a place from which to act. There are only persons. Selves are grammatical fictions, necessary characteristics of person-oriented discourses.

The notion of the self as entity is, suggests Harré (1998) a "useful fiction, but ultimately seriously misleading". Indeed, Harré (1998) suggests that it may be helpful to move away from the notion of 'the self' and talk instead of a "person's senses of self". As Harré (1998, p. 4) notes there are a number of 'aspects' to a person's 'sense of self'. Firstly, to have a sense of self is

> to have a sense of one's location as a person, in each of several arrays of other beings, relevant to personhood. It is to have a sense of one's point of view . . . a location in space from which one perceives and acts upon the world, including the part that lies within one's own skin.

Secondly the phrase 'sense of self' is often used to refer to

> The sense one has of oneself as possessing a unique set of attributes which, though they change nevertheless remain as a whole distinctive of just the one person.
>
> (Harré, 1998, p. 4)

Finally, the notion of the 'self' is also often used to refer to the impression that a person makes upon other people, either purposely or accidentally. Thus, in Harré's (1998) analysis we have three 'aspects' of the 'self', which Harré (1998) refers to as Self 1, Self 2 and Self 3.

Self 1 is having "a sense of a field of things centred on one's own embodied self with which one is in a material relation" (1998, p. 104). As Harré (1998, p. 96) points out, however, the pronoun 'I' doesn't just indicate a person's spatio-temporal location but it also indexes what is said with "the personal responsibility of the speaker". Thus, Self 1 also has another, and related, aspect; the discursive presentation of the person as "a responsible and active being – person as agent" (1998, p. 96).

Self 2 includes "the totality of attributes both ephemeral and enduring of the person I am" (Harré, 1998, p. 148). Included in these attributes are "one's beliefs about one's attributes" (Harré, 1998, p. 4). There are two aspects to Self 2, what one currently is (self-knowledge or self-concept) and what one has been (autobiography). Self 2 encompasses the "ephemeral flows of activity, both private and public, in which that person engages, producing thoughts and actions sometimes but not always displaying repeated structures and forms" (1998, p. 135).

Self 3, in Harré's (1998) analysis, is essentially "the impression of a person's personal characteristics that one person makes on another" (Harré, 1998. p. 4). There are two aspects to Self 3; "the self I intend to project in what I say and do" and "the self that others read in my speech and action" (Harré, 1998, p. 177).

Harré's (1998) schema can be represented as having the following structure:

Person {Self1, Self 2, Self 3}

According to Harré (1998, p. 9) the "person is the robust existent and the three bracketed concepts refer to aspects of and conditions for the flow of personal action". As has already been noted, for Harré (1998) the word person refers to "the embodied, publicly identifiable and individuatable and unanalysable being around which the human form of life revolves" (Harré, 1998, p. 177). Persons are "both materially embodied and enmeshed in networks of symbolic exchanges, which are, at least in part, constitutive of what they are" (Harré, 1998, p. ix).

In Harré 's (1998) analysis the "'person' is the genuine substantive, picking out a category of real entities [but]. . . the three 'selves' discussed above are ontologically quite different" (Harré, 1998, p. 148). These expressions refer not to entities, as already noted above, but to

> attributes of the flow of personal action, and to the skills, powers and dispositions a person must have so to act. As entities, Self 1, Self 2 and Self 3 are fictions, though indispensable fictions.
>
> (Harré, 1998, p. 148)

For Harré (1984a, p. 26), while the concept of self is the "central constructing concept of individual human psychology", it is a

> theoretical concept whose source analogue is the socially defined and sustained concept of 'person' that is favoured in the society under study and is embodied in the grammatical forms of public speech appropriate to talk about persons. Our personal being is created by our coming to believe a theory of self based on our society's working conception of a person.

Harré (1998, p. 72) emphasises that it is "persons who are the basic particulars of the human world. It is as persons that human beings belong in that world, not as organisms". For Harré (1998, p. 5), selves, either as "personal points of view [Self 1] or as dynamic totalities of personal attributes [Selves 2 and 3]" are aspects of persons that exist primarily in discourse. Selves exist in the stories we tell in which our uniqueness is established and displayed *for ourselves* and for others. As Harré (1998, p. 19) notes,

> [u]nless we take the greatest care in how we interpret ways of expressing ourselves as persons we can easily begin a multiplication of sub-personal entities, homunculi of various sorts, for instance 'self as mental mover' or 'self as mental contents'.

Harre's suggestion that the 'self' is socially constructed throws into disarray the commonly held belief that "to be a person is [to] possess an inner psychic unity (which we call our 'self')" and the related beliefs "that it is from our self that all our motivations issue, and that it is within our self that all the reasons for all our actions can be found" (Shotter, 1993a, p. 95). As Shotter (1993a) points out, such an analysis, shared in general terms by Shotter (1993a; 1993b) himself and by most other social constructionists, suggests that rather than our activities being the product of our motives (which issue from the centre of our being, our 'self'), our motives are actually the product of our activities.[16]

Harré (1998, p. 59) suggests that it is somewhere in the "grammar of the personal pronouns, particularly the first person and to a lesser degree the second" (Harré, 1998, p. 55) that we should be looking for "an expression of the seemingly elusive sense of self". Harré (1998) suggests that first and second person pronouns are used for the expression of all three aspects of self (Self 1, Self 2 and Self 3). Third person pronouns and proper names, on the other hand, "are used to pick out persons as publicly identifiable individuals and refer to none of the discursively constructed pseudo-entities, Self 1, Self 2 or Self 3" (Harré, 1998, p. 65).

In order to support his arguments concerning persons and their selves Harré (1998, p. 17) depends heavily on a linguistic analysis which is "directed towards

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[16] This social constructionist insight is an interesting one in that it completely reverses the accepted view of where our motives issue from. Certainly in the case of many motives it would seem to provide a more accurate account. For example, if we are motivated to go and meet a friend for coffee it may be because we have had previous pleasurable interactions with this friend, thus ensuring we will seek them out again. Or it may stem from our friend exerting pressure on us to meet for coffee ("you haven't had much time for me lately" or "I need to talk to you about something"). Both of these possible reasons would also interact with other factors such as our need to socialise regularly or our lack of ability to say no to someone, both of which are also the product of our past and present activities in the world even though they have now become part of our 'self concept'. But what about those motivations we feel without really understanding where they come from? Our sudden urge to touch that lamppost as we walk past it. Our strong desire to avoid a particular street as we are driving about town, even if it would get us to our destination faster. Our need to eat that fourth cream cake even though we are full to bursting. There seems to be no relation between our activities in the world and these strange urges. For many, these motivations seem to come from within, from our deepest core. Indeed, many of the 'symptoms' of the so-called 'mental disorders' outlined in the Diagnostic and Statistical Manual are of just this character. Strange urges, unexplained fears, baffling desires and mysterious sadness; feelings which do not seem to have any real link to our actual lived lives. In Section 3.3, however, it will be argued that these feelings/motivations can be shown to come from our activities in the world as surely as do the simpler more 'explainable' motivations. As will be noted at the end of this chapter, however, in order to more fully understand such experiences, it must be acknowledged that they are not just 'socially constructed', rather they are socially and biologically co-constituted. It will be the task of the remaining chapters in this thesis to outline how such 'co-constitution' occurs.

showing that 'I'. . . is not a referring expression like a proper name or an unambiguous description". According to Harré (1998, p. 17)

> the only referring expressions in the language games of self-attribution and description are proper names and their equivalents and they are used to refer to actually, formerly or potentially embodied persons.

First and second person pronouns, rather than referring to actual embodied persons, are used for the expression of all three aspects of the discursively constructed self. This is because these words are *indexicals* and thus carry with them grammatical properties that locate a person in place and time. The use of 'I', for example, indexes the content of a report about the world with the point of view of the speaker and, according to Harré (1998, p. 55) "implies a centring among material things in the environment and also among the parts of one's body as territory within the larger territory".

Harré (1998, p. 56) suggests that the meaning of 'I' is

> completed on an occasion of use by local knowledge of the location of the body of the speaker. By virtue of that fact about its usage the situated use of 'I' indexes the empirical content of a descriptive statement with the spatial location of the embodied speaker.

But there is another 'location' which the word 'I' indexes and that is the speaker's location or 'position' in the local moral order (Harré, 1998; Harré & Gillett, 1994). If someone says "I think the Headmaster is a fool" our assessment of whether the speaker is reliable or unreliable, fair or unfair, etc., will influence how we respond to what s/he has said. This aspect of an utterance is called its 'illocutionary force'. Thus, the pronoun 'I'

> does the work of indexing these aspects of a statement with spatial locations and moral positions. My sense of self, of my individuality, is in part my sense of experiencing the world from a unique location in space, the location of my body. It is also, in part, my sense of acting on the world at that place, but also in relation to other people. My moral position is also implicated in my sense of my own agency. It is an essential component of the sense of self, and it is manifested in the role of the pronoun that presents the speaker as a self.
>
> (Harré and Gillett, 1994)

As Harré and Gillett (Harré & Gillett, 1994, p. 197) go on to note "[p]ersonal identity is one's sense of being located in space and having a position in the moral order of the little group with which one is conversing". They conclude that "selfhood is discursively produced for others by the use of the first person pronoun, and at the same

time is discursively produced for ourselves. It reflects and in part engenders my own personal identity" (Harré & Gillett, 1994).

Harré's analysis of the 'grammatical fictions' that are our 'selves' makes very clear how the ways in which we use language have essentially 'tricked' us into believing in the existence of a variety of 'object-like' entities – the 'self', the 'ego', the 'soul', and etc. As Harré (1998, p. 61) notes "'I' is part of the grammatical machinery by which I express my point of view, not a device for referring to a subject [e.g., the 'inner self' or the 'mind'] to which properties and states are being ascribed". Thus, when someone says they 'see' something, all they are doing is describing "some state of the world, indexed with the point of view (the location of the speaker's body) from which it is seen" (Harré, 1998, p. 60). There are no extra entities (e.g., 'selves', 'egos') doing the seeing, there is only the person[17].

As Harré (1998, p. 17) notes "the indexical force of the first person is nothing other than incorporating the locations of speaker and act of speaking in the manifolds presupposed in perception, action and memory in discourse". Harré (1998, p. 17) goes on to argue that

> [s]ince there is but one person marking device in the grammar of which a person's locations in all three manifolds are expressed, namely 'I', it is that device that pins together the otherwise disparate locations into the one person that each of us is. The psycholinguistic thesis of the social construction of selfhood is simply that in acquiring the grammatical capacity to use the first person devices the singularities of self are brought into coordination as the sense I have of my own personal being as a singularity, my continuous point of view.

For Meares (2000, p. 11), also, 'I'

> is primarily a noun of 'position', a metaphoric 'eye' from which attention is directed, so shaping an individual reality, which is in a state of ceaseless change. The 'I' is a constant, offering a means of unifying personal existence. In this way one's person is conceived as a unified diversity.

According to Harré (1998), and Shotter (1974a, 1974b), it is within the symbiotic relationship between a child and their mother that the 'grammatical fictions' that are our 'selves' are established, and it is these senses of 'self' which essentially comprise our 'personal being'. Again, this accords with the work of Meares (2000, p. 14), who notes

[17] It should perhaps be reiterated here that in Harré's schema Person{Self 1, Self 2, Self 3} the three 'selves' are *not* entities, rather they are various aspects of our multi-faceted 'sense of self'. It is not any of these 'selves', as articulated by Harré, who are 'doing the seeing', it is the embodied person.

"[w]e are not born with a 'self'. It is a potentiality, to be realised in the context of a particular form of relationship with others".

3.2. THE SOCIAL CONSTRUCTION OF OUR SENSES OF 'SELF'

3.2.3. Psychological symbiosis: Laying the foundations for personal being

As already noted in Section 3.1.2, for both Harré (1998) and Shotter (1974a;1974b; 1984) the processes which transform a child into a 'person' take place primarily during a period some theorists have called 'psychological symbiosis' (Newson & Shotter, 1974; Spitz, 1965) – a stage beginning with the first smile and ending when the child's use of language becomes sophisticated enough to enable them to engage in private discourse and carry out complex cognitive acts for themselves. As has also already been noted above, it is within this symbiotic relationship, according to Harré (1984a, p. 105) that "certain kinds of language games[18] are played, engendering talk with appropriate cognitive properties, for instance self-expression of feelings and intentions"[19], language games essential to the emergence of our sense of 'self' as a unique individual with a point of view, agentic powers and a personal life trajectory which we can narrate to ourselves and to others.

Psychological symbiosis, as defined by Harré (1984a, p. 105) is

> a permanent interactive relation between two persons[20], in the course of which one supplements the psychological attributes of the other as they are displayed in social

[18] Language games (Wittgenstein, 1953) are essentially the enactment of language in the everyday activities of people, their 'forms of life'.

[19] It should be noted that this early pre-linguistic stage of development was not the focus of Vygotsky's research, and indeed in many of his writings he appears to claim that the 'mental functions' children are capable of at that age are automatic and innate within the personality. As Burkitt (1991, p. 152) points out, however, there is "now evidence to suggest that children actively begin to appropriate the social heritage, and to construct their personality under the influence of their culture, before they have acquired linguistic competence". While this early pre-linguistic stage of development was not the focus of Vygotsky's work the findings to be discussed below nevertheless "complement his work and extend the spirit of his enquiries to the pre-linguistic stage of childhood" (Burkitt, 1991, p. 152).

[20] While the infant is not, at this stage, a 'person' in the Harréan sense it is, nevertheless, in the process of becoming a 'person' and, as will discussed in this chapter, is treated as a 'person' by its mother and significant others in its life. Indeed, Harré (personal communication, cited in Tissaw, 2000) suggests that without this assumption on the part of the mother that her infant is a 'person', personal being could not be achieved.

> performances, so that the other appears as a complete and competent social and psychological being.

Drawing on Spitz's (1965) descriptions of mother-infant interactions during the first year Shotter (1984), offers a three-stage account comprising of (1) 'initial stages', (2), 'continuation', and (3) 'end' outlining the changes that take place during the period of symbiosis. Describing the beginning of the initial stages, Shotter (1984) notes how human babies are essentially "adapted to a complete dependence upon an adult human being." (Shotter, 1984, p. 57). He also notes that they are born into a 'love relationship' (although this is not, of course, always the case) "which is inherently personal" Shotter (1984, p. 57) suggests that human infants

> must be treated as if they are already persons who can intend purposes; they cannot think for themselves, yet they cannot live without thought, so some way must be found of having their thinking done for them.

Shotter (1984, p. 57) further argues that

> until they have 'constructed' their own thought 'mechanisms' . . . by their mother's courtesy, they use their mother as 'mechanisms' to do the thinking required in the realization of their intentions for them.

While in the initial weeks of life babies have always been seen as completely helpless research has shown that babies are actually born with a range of orienting, approach and expressive behaviours that allow them to immediately 'join the conversation' around them. Some of these behaviours are 'innate', while others, as Polan and Hofer (1999b) have shown, are learned before birth, as will be discussed in more detail in Chapter Four.

Such behaviours then serve as the building blocks from which the kind of psychologically symbiotic relationship described above can be constructed. For example, less than an hour after being born babies will draw back their heads to look into the face of the person who is holding them and within a few hours will turn their head in the direction of their mother's voice (Taylor, 2002). And from the first day of their life infants will move their body in synchrony with adult speech (Small, 1998, p 36). The human baby, as Taylor (2002, p. 39) notes, "begins life primed to be social".

These behaviours and abilities allow for a rapid increase in responsiveness on the part of the infant towards its mother in the first few weeks (Meares, 2000), thus enabling the initiation not only of the biologically symbiotic relationship which will be discussed in some detail in Chapter Four, but also of a 'psychologically symbiotic'

relationship. As Shotter (1984) points out, this growing responsiveness results in a qualitative change in the interactions between the mother and the infant over the first few weeks of life so long, of course, as the mother is adequately responsive[21] towards the child. As Shotter (1984) points out, the first stage of the symbiotic relationship between the mother and her child is a very important one and for things to proceed well a relationship is required within which each member pays total attention[22] to the other while they are together (Shotter, 1984).

Drawing on Mead (1934, cited in Shotter, 1984), Shotter (1984, p. 58) notes that "such interlaced but spontaneous activities are a form of communication, even if they cannot be said to constitute a language – as they are not of the form in which a stimulus affects the individual who makes it in the same way as the one who receives it". Shotter (1984, p. 58) goes on to note that "the sort of perception involved in these exchanges – of the expression of feeling or affect – is very primitive", with the participants, he suggests, acting purely as natural agents or 'biological individuals'. This very basic physical-affective relationship becomes 'psychological', or 'personal', when behaviours such as smiling and reaching for specific objects "result in attempts on the part of the mother to interpret and/or complete what appear to be intentional or other actions that may be described through use of psychological predicates" (Tissaw, 2000, p. 856).

Indeed, as Tissaw (2000) notes, following a suggestion made to him by Harré (personal communication, February, 1997, cited in Tissaw, 2000, p. 850), the assumption on the part of care-givers that infants' behaviour is intentional or moral "is integral to psychologically symbiotic exchanges and, indeed, to normal[23] psychological development". Shotter (1974a) also argues that a child can only act because his/her mother acts as if she understands him/her, and mothers act in this way because they credit their children "with human qualities and sensitivities" and react towards them as

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[21] As the research cited in this chapter and in subsequent chapters highlights, there are some basic acts mothers need to do in relation to their children and if these are not done there are adverse consequences for the child. The phrase 'adequately responsive' essentially means that the mother has fulfilled these basic requirements.

[22] Research suggests that such preoccupation with the infant is very common, for both mothers and fathers during the very early weeks of parenthood, although mothers are generally much more preoccupied than fathers. In a study by Leckman, Mayes, Feldman, Evens, King & Cohen (cited in Mayes, Swain, & Leckman, 2005), for example, mothers of normal infants two weeks after delivery reported spending nearly fourteen hours per day focused exclusively on their infant. Fathers reported spending approximately half that time. As Mayes et al. (2005, p. 303) note, such parental preoccupations also include "thoughts of reciprocity and unity with the infant, as well as thoughts about the perfection of the infant".

[23] The difficulties with such a value-laden word as 'normal' are acknowledged. While there is no such thing as 'normal' development , however, there are developmental trajectories that lead to less suffering than others within certain socio-cultural contexts. It is presumed that what Tissaw is meaning here is that 'normal' psychological development results in the person living a life that is relatively free from the kinds of psychological suffering which are the focus of this thesis.

"potential human beings" (Newson, 1979, p. 210). Thus babies are in a personal relationship with their mother right from the start and, as McMurray (1961, p. 50, cited in Shotter, 1984, p. 82) puts it, they live "a common life as one term in a personal relation".

In treating her infant in personal terms, according to Shotter (1984) a mother does two things. First, she attempts to elicit from her child certain kinds of activity. Shotter (1984, p. 82) suggests that many of the activities the mother attempts to elicit from the child are already present within the child's repertoire, either innately or due to prenatal learning but that without the mother's "intelligent adjustment of the eliciting circumstances [much of this behaviour] would undoubtedly remain unexpressed". By doing this a mother 'affords' or acts to motivate certain types of activity in her baby thus providing what Schutz (1953, cited in Shotter, 1984) would call a 'because-motive' for the child. Second, the mother, having motivated some sort of activity in her baby, then interprets it as having meaning.

The important point here, notes Shotter (1984) is that even though mothers actively attempt to elicit certain activities from their babies when the babies comply the mothers still interpret their babies' activities as something which comes from the baby, not just something they have succeeded in getting the baby to do. Their babies' behaviour is "thus treated as activity worthy of being an expression in a dialogue, an expression requiring a meaningful reply" (Shotter, 1984, p. 83). In so doing, mothers supply their children with what Schutz (1953, cited in Shotter, 1984) calls an 'in-order-to' motive as well. In these situations babies learn what they can cause to happen through their own actions.

Thus, as Newson and Newson (1975, p. 442, cited in Shotter, 1984, p. 84) point out, the various action sequences elicited by mothers and performed by infants are therefore a combination of the infant's "own activity and an intelligent manipulation of that activity by the much more sophisticated adult partner". It is in this sense, argues Shotter (1984, p. 84)

> that children can be competent participants in such interactive exchanges as these (in a way that, presumably, other organisms could not), that they may properly be counted as one term in a genuine personal relationship.

These very early 'language games', as Harré (1998) refers to them, between mother and child have the form of a conversation which includes vocalisations, but it also includes facial expressions, body movements and tone of voice. Trevarthen (1987, p.

365, cited in Meares, 2000, p. 17) notes that microanalysis of ordinary face-to-face play between mothers and their babies reveals

> precise conversation-like timing in the way they address one another and reply. Babies stimulate gentle and questioning 'baby talk' which has a regular beat and characteristic expression of mood in its changing intonation, rhythm, and accompaniment of movements of head, eyebrows, eyes, and so forth. The infant watches the maternal display intently and then makes a reply, on the beat, with a smile, head and body movements, cooing, hand movements, and even lip and tongue movements which are called 'pre-speech'. Photographic records suggest they are developmental precursors of actual speech. These attempts at vocal expression are synchronised with hand gestures.

The work of Bateson (1979) gave definitive recognition, and the name "proto-conversation, to this behaviour, identifying it "as a form of instinctive communication that lays the ground for learning of language" (Trevarthen, 2001).

As Meares (2000, p. 16) further notes

> the movements, gestures, and expressive vocal tonings of the mother-baby dyad are finely co-ordinated so that the behaviour of one is dependent on the behaviour of the other. Although the interchange appears simple, it consists of a fluid and complex stream of behaviours which are interwoven and extremely difficult to code.

This links to research within the field of 'emotion regulation' the results of which suggest that during infancy "successful [emotional] regulation largely depends on caregiver support and flexible responding". Such regulation "occurs through specific patterns in which the matching of affective states and reparation of interactive and affective 'mismatches' . . . have fundamental importance" (Reck, Hunt, Fuchs, Weiss, Noon & Moehler, 2004, p. 273). As Tronick (1998, p. 294) points out, "the typical mother-infant interaction moves from coordinated (or synchronous) to miscoordinated states and back again over a wide affective range".

Tronick (1998) refers to these miscoordinated states as 'miscommunications'. As Tronick (1998) points out, however, these 'miscommunications' are normal events that occur when one of the partners fails to accurately appreciate the meaning of the other's emotional display and in turn reacts in a way that was not expected. When the mother and the child interact in such a way as to move from a miscoordinated state to a coordinated state Tronick (1998) refers to this as 'interactive repair'.

It is from within these very early, pre-linguistic, symbiotic interactions between the mother and the child, suggests Harré (1998), that the two aspects of our personal being which comprise 'Self 1' begin to emerge – the sense of oneself as "the centred

structure of our own perceptual field" (Harré, 1998, p. 95) and (b) the sense, and eventual discursive presentation, of oneself as an agent. As Harré (1998, p. 104) points out, Vygotsky's research suggests that the origins of the first sense of 'Self 1' "lie in the manipulative practices with which . . . an infant begins to appreciate its world as ordered, with respect to its own position as an embodied being among other things and beings of that or similar sorts".

Harré (1998) suggests that there is never a Jamesian 'blooming buzzing confusion'; we do not begin our lives experiencing the world as an array of elementary sensations. Our perceptions of the world are always structured because they are centred on our bodies and organized around our point of view. "Objects are perceived as standing in spatial relation to the embodied perceiver" (Harré, 1998, p. 104). As Harré and Gillett (1994, p. 108) elaborate

> [i]f one looks out from one's eyes and listens with one's ears and pays attention to the bodily tactile sensations of which one can become aware at this moment, one finds oneself at the center of one's own material body. That, in a first approximation, is a beginning to an investigation of the structure of consciousness. One can become conscious of the fact that all that one perceives is structured around a kind of center, as Husserl (1973) called it, the "I" pole.

For Harré (1998, p. 107) "consciousness, being aware of something, is a relation between a person and an intentional object" (which may be either outside – i.e., perception – or within – i.e., proprioception, the envelope of the skin), it is *not* the property of a person alone. The idea of consciousness being relational is in line with Shotter's position (1974a, p. 148) that perception seems to be an active process at every level, building on our basic "intrinsic processes of mental organization". Shotter (1974) draws attention to the work of Bohm (1965, p. 203, cited in Shotter, 1974, p. 148) who argued that we do not perceive a stimulus simply for what it is in itself, what we perceive contains "structural features which are not even on the retina of the eye at a given moment, but which are detected with the aid of relationships observed over some period of time".

As Bohm (1965, p. 211, cited in Shotter, 1974, p. 148-49) notes

> a person must actively meet his environment in such a way that he coordinates his outgoing nervous impulses with those that are coming in. As a result the structure of his environment is, as it were, gradually incorporated into his outgoing impulses, so that he learns how to meet his environment with the right kind of response.

Thus, as Shotter (1974a, p. 148) points out, what we perceive lies in the way we "relate our actions and their consequences, and, of course, as infants such relating will need to be scaffolded by others in our social world. Perceiving is a skill, one based upon natural powers but augmented over time by our experiences in the world". Thus, during the close interactions between mother and child, characterised by Shotter (1984, 1993) and Harré (1984a, 1998) as psychological symbiosis, the child begins to gain a sense of him or herself as something separate from other people, as a 'self' that can perceive the world from a particular vantage point, a being with a 'point of view'.

The second aspect of Harré's 'Self 1', our sense of ourselves as an agent in the world, also begins to emerge during this stage from our immersion, and our participation, in the discourses we are surrounded by (Harré, 1998; Harré & Gillett, 1994). As Harré (1984a, p. 180) points out, the self as agent is not a mysterious thing involving all sorts of sub-personal dispositions, rather it is "a belief which endows the believer with certain powers of action in accordance with the interpersonal models available in the society". Harré (1984a, p. 193) suggests that our understanding of ourselves as agents should be seen as "the employment of a theory with the active and willing self as its prime theoretical concept".

Harré (1984a, p. 193) suggests that this theory of ourselves as agent is learnt by the same Vygotskian processes as are all other aspects of our personal being, thus

> by being forced to listen to the exhortations of others, I learnt to exhort myself, and by watching others push each other into action, I learn to bestir myself. It is my grasp of the theory that I am a unified being that enables me to understand that I am the recipient both of exhortations and kicks and shoves, and that I can exhort and shove others, and, finally, putting all this together, that I can so treat myself.

As Harré and Gillett (1994) note, it is via our immersion in the various discourses that comprise our social world that we learn the various 'rules of engagement', and realise which rules are validated within which discourses. According to this view, right from the beginning our "intentions are structured by and emerge from the positions taken up in a social context and the discourses that pervade and structure it" (Harré & Gillett, 1994, p. 122)

For Harré and Gillett (1994), the validations operating within discursive contexts together with a person's 'self-location' or 'positioning' within these contexts emerge as the crucial factors influencing the attainment of a sense of control over one's actions in real-life situations. 'Validations' essentially provide people with options to look at a situation in one way rather than another and they also recommend commitments to

certain positionings within a discourse. Thus, there will be certain 'options' within the discourses that surround us that are validated, and others which are not.

It is likely then, that the options that were validated or invalidated during the discourses that surrounded us in our childhood would exert a particularly potent effect on our actions throughout our lives. In many, indeed most, cases people would not be able to articulate or understand why certain options seem impossible to them, or why certain other options seem so compelling – even in the face of good 'rational' reasons to do or not do this or that. This would be particularly the case if they were still being affected by the validations and invalidations that were part of the discourses of their formative years.

At the same time as the interactions in the mother-child relationship are scaffolding our emerging sense of ourselves as agents, and shaping what we feel we can and cannot do in the world, these interactions are also scaffolding the foundations for the acquisition of the powers crucial to the emergence of Self 2 (and, also of Self 3, which is essentially just the public 'presentation' of Self 2) – self-expression and self-reference. As Meares (2000, p. 85) points out, during early infancy the baby does not conceive of him/herself as a 'self', and "cannot view his or her experience in the manner of the stream of consciousness . . . The mother, however, shows the baby what he or she feels like". As research with mother-baby dyads shows, the mother's "responses to the baby, although they do not precisely imitate the baby's facial and vocal expressions, closely resemble them, adding to them, showing them in a somewhat elaborated form" (Meares, 2000, p. 85).

Thus, Meares (2000, p. 85) suggests that in the beginning "the face and voice of the mother is where the baby's existence as the 'me' resides". In other words, Meares (2000) is suggesting that within the psychologically symbiotic relationship between the mother and the child, the mother "enacts a germinal 'me' in relation to the baby's rudimentary 'I' (Self 1) in order to 'call out' or 'scaffold', in the Vygotskian sense, the baby's emerging 'me' (Self 2).

Once the child gains even a basic facility with language the location of this 'me' shifts from the mother to the child. As was pointed out above, during development there usually is "a transfer of the control of action from one individual to another" (Lock, 1981, p. 29). This transfer occurs through the development of the ability to use symbols, particularly, though not solely, 'linguistic signs' (Lock, 1981). As Lock (1981, p. 29) points out, the child learns to control processes that he "previously could not by an

'internalization': his individual construction of the symbolizing other". It is at this point, then, that the child begins to utilise language not only to communicate with others, but also to communicate with him/herself.

Harré (1998, p. 27) suggests that at this stage a child is "beginning to develop the capacity for private discourse". This enables the child to "perform complex cognitive acts for itself", thus facilitating

> higher level cognition by making possible retrospective and anticipatory commentary first upon the overt acts of public life and then on its own discursive practices, modelled on the commentaries to which its speaking and acting have been subjected by others.

As Meares (2000) points out, such 'private discourse' is particularly obvious during children's play. Meares (2000) notes, however, that children are not, during such play sessions, talking themselves. Rather they are "talking to a part of the external world, which [they have] imaginatively created . . . an illusory person who is a condensation of the parent experienced in this way and a double of himself" (Meares, 2000, pp. 22-23). Thus, although children who are engaged in this kind of play seem oblivious to others Meares (2000) suggests that "the sense of a presence of another, the caregiver, permeates the whole experience".

Meares (2000) notes that the chattering that accompanies symbolic play takes a conversational form, with the child often switching between two or more viewpoints, as in the following example from Kohlberg et al. (1968, cited in Meares, 2000, p. 149):

> The wheels go here, the wheels go here. Oh, we need to start it all over again. We need to close it up. See, it closes up. We're starting it all over again. Do you know why we wanted to do that? Because I needed it to go a different way. Isn't it going to be pretty clever, don't you think? But we have to cover up the motor just like a real car.

This kind of 'chatter', as has been noted in Section 3.1.2., is representative of Vygotsky's 'egocentric speech' stage when the child uses words "to guide its own behaviour by talking aloud to itself as an adult would who was giving the child instructions" (Burkitt, 1991, p. 147). Such talk, suggests Meares (2000, p. 24), is "qualitatively different from that used for communication and for ordinary coping with the environment". It often lacks the grammar of ordinary communicative language, and "moves capriciously according to association and analogies" (Meares, 2000, p. 25).

As Meares (2000, p. 24) notes, while chattering in this way the child "is in a state which is embryonically 'inner'. The child's experience . . . is equivalent to that of an adult who is lost in thought". Such chatter, suggests Meares (2000, p. 25) becomes,

essentially, "an embryonic narrative of self . . . representing and so bringing into being, the sense of self" (Meares, 2000, p. 25).

It is at this stage, according to Harré (1998), that the period of psychological symbiosis essentially ends. As Newson and Shotter (1974) note, once language has been introduced this lessens the child's reliance on the mother and gives them "access to a more universal, established system of intersubjectively significant gestures". At this point the child becomes amenable to other sources of cultural influence (such as teachers and peers).

It is suggested that if the child-caretaker communicative system has not functioned well[24] during this period then this compromises the very foundations upon which personal being and our 'senses of self', as outlined by Harré (1998) and Meares (2000), depend for their emergence. As has already been noted above, a feeling that our 'self' has somehow been disrupted, fragmented, split, devalued or lost are central to the experience of the kinds of psychological suffering outlined in the DSM-IV-TR (American Psychiatric Association, 2000). If these foundations are compromised then this, as will be outlined in more detail in Chapter Five, leaves the child vulnerable to suffering in ways which may result in the 'clusters of suffering' referred to as 'mental disorders. I will go on to discuss, in Chapter Six how such vulnerabilities may, depending on the complexities of a lived life, contribute to two particular 'clusters of suffering' those conceptualised as 'schizophrenia' and 'depression'.

3.1.4. Transforming natural powers into personal powers: The emergence of personal being and our senses of 'self'

Once children are able to move around independently and to "actively deny their mothers the option of influencing them" (Shotter, 1984, p. 64) their mothers, who previously only had to gratify (or not) their child's needs, now find themselves having to curb and prevent some of their child's initiatives. Thus, according to Shotter (1984), the period of 'social games' begins. As Shotter (1984, p. 65) points out, to be able to play such games children

> must first develop a clear distinction between people and things (animate and inanimate), and then learn as their first social skill how to open and close the social link

[24] In the sense of having not prepared the child well for the social world which s/he must live out his/her life.

> at will. And a part of being able to do that is being able to acknowledge the humanity, the autonomy and cognitive status of the other by some form of greeting – even if only a smile. Self-conscious beings recognize themselves as mutually recognizing one another.

Vygotsky (1966a, cited in Shotter, 1984, p. 65), suggests that children's play at this stage is essentially "an expression of the child's basic needs and desires, structured as a result of the child's earlier action exchanges with adults and the world". Thus, according to Vygotsky (1966a, cited in Shotter, 1984), when children play they do not understand what they play, rather they play in accord with this 'internal structure'. Vygotsky (1962) calls this an 'imaginary situation'. Shotter (1984) stresses that they do not play according to rules. The establishment of rules, rather than being an essential part of this process is actually the final consequence of it. And any rules there are in child's play are not thought out in advance but arise instead in the course of interacting with others in a coordinated way (Shotter, 1984).

As Shotter (1984) points out, the people and the objects in a young child's world usually dictate themselves how they must be used but in play this is no longer the case. In the imaginary world of play children can regulate their own behaviour not by reference to how the 'things' in their environment would normally be used but according to the *meanings* that the children assign to them. Their behaviour, notes Shotter (1984, p. 66)

> has ceased to be wholly context-dependent and begun to be structure-dependent, in Chomsky's (1972) sense of the term; that is, its elements have their significance in terms of the part they play in relation to the field of possibilities inherent in children's image of their play-world.

While children of this age are not at the stage of symbolism involving rules yet, "the affective meanings children assign to 'things' dominate and determine their behaviour towards them" (Shotter, 1984, p. 66). Of course if 'things' can mean virtually anything within the context of play, meanings and 'things' could never become linked in any determinate fashion without the involvement of other people in the process. It is because adults and older children within a child's environment (at this stage most often the child's mother[25]) require the child to "co-ordinate their activity with theirs in relation to definite criteria which are important to them in some way" that such links begin to be

[25] Again, the point must be made that the mother may not be as central to this process for children in non-Western cultures. As Blaffer Hrdy (1999) notes, while mothers are central to their child's very early lives in every culture in many cultures they quickly become less central as other members of the tribe/village, such as grandmothers, aunts and older girls, begin to take on care-taking roles and the children, as they become ambulatory, begin to move out on their own accord, into the wider social world.

forged. Thus while adults and older children, in a play situation, cannot instigate a child's activities they can exert "powerful controlling influences" (Shotter, 1984, p. 67).

Mothers, in particular, can do this because they know their children intimately from their earlier unspoken and emotional relationship and mothers are still the primary means of their children's gratification. Thus, suggests Shotter (1984, p. 67), mothers "make use of this relationship time and again to draw their children into involvements which, if left to their own devices, they would never otherwise undertake". Once again, there are no absolute rules or criteria regulating such exchanges, rather, the participants "negotiate the rules as required" (Shotter, 1984, p. 68). Thus the interactions between mothers and their children scaffold the child's play, allowing the child to function beyond their actual developmental level, reflecting Vygotsky's theory of the 'zone of proximal development', as outlined above.

This is illustrated by research which shows increases in the diversity of children's play (a measure which research suggests is related to later play sophistication and intelligence) during play with their mother as compared to solitary play (O'Connell & Bretherton, 1984, cited in Damast, Tamis-LeMonda, & Bornstein, 1996). O'Connell and Bretherton (cited in Damast et al., 1996, p. 1753) suggest that it is "not simply a mother's presence, but her active participation that accounts for differences in children's play across social contexts". Tamis-LeMonda and Bornstein (1991, cited in Damast et al., 1996) found that the play behaviour of mothers (i.e., their demonstrations, and their gestural and verbal solicitations) with their children "relate to their children's play behaviors: Mothers who engage in more symbolic play with their 13- and 20-month-olds have toddlers who engage in more symbolic play at these ages" (Damast et al., 1996, p. 1753).

As Shotter (1984, p. 68) points out, the most important skill children acquire in the course of their 'games' with their mothers, and other significant adults / older children in their lives is

> the skill to make meanings of their otherwise indeterminate actions determinate as required, by co-ordinating their behaviour with others, and by making implicit or explicit agreements with them one way or another.

As Shotter (1984, p. 68) further notes,

> the relationships that people have to one another, besides having an aspect of mutual use, also provide a reciprocated access to being – people help one another to be themselves.

Once children are capable of participating in the kind of social games and symbolic play outlined above the transformation of their 'natural' powers – made available to them from their surroundings (social and physical) – into 'personal' powers can begin. If one is going to be a person[26], suggests Shotter (1984, p. 75) "an autonomous individual acting in the knowledge of who and what one is, and what one is trying to do in relation to all the others with whom one is sharing one's life", then you need to do more than just behave in ways that others can recognise. You need to be able to recognise what you are doing yourself.

While the child, as a biological organism, may have the capacity to act in a number of different ways the source of the knowledge about how these otherwise indeterminate capacities might be used, as has already been noted above, lies within the social ecology within which the child is embedded. In other words,

> the knowledge which children must acquire if they are to learn how to put their innate capacities to use, intelligibly and responsibly, to do the 'done things' in their society, is 'out there', in their society, encoded not as ideas in people's heads but . . . spread out in the practical activities of everyday life".
>
> (Shotter, 1984, p. 75)

Thus, according to Shotter (1984, p. 173), persons are constituted, in a very deep way, "by the sense-making procedures made available to [them] by the social order (or orders) into which [they] have been socialized; procedures which have their provenance in the history of our culture". Such procedures enable the members of a social order not only to account for their actions to themselves and to each other, when they are required to do so, but also enable them to "act routinely in an accountable manner" because their actions are informed, as their performance unfolds, by these procedures. Such procedures also put limits on what people can say or do because people must, to be full members of a social order, "talk and act only in ways which are intelligible and legitimate within their society, and which are appropriate to their momentary position (or status) as the persons they are within it".

As Shotter (1984, p. 178) points out, "all 'I's' need 'you's' if they are ever to appear in the world to themselves as 'me's', and to possess well-defined social identities". They also need 'you's' in order to learn how to be all the 'persons' they need to be in order to be fully functioning members of their society; listeners, speakers, spectators, thinkers, rememberers, imaginers, storytellers, requesters, insulters, and etc.

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[26] Once again, we are talking here about a Western 'person'. The general point, as made quite clearly in the following paragraph, however, that children become fully participating members of their society by being immersed in the practical activities of everyday life, including the social interactions, within that society would, it is suggested, hold true for every human society.

All this necessitates them "learning how *to do* certain things within themselves, some 'ontological skills', not just 'facts' about such activities: they have to learn to articulate their own relation to themselves in a socially appropriate manner". And children learn these 'ontological skills' within the context of relationships with significant others in their social world via the kind of Vygotskian processes outlined above.

Three of these 'ontological skills' – the development of the capacity for what Vygtosky refers to as 'inner speech', the ability to construct a coherent narrative about past events and the self-reflective capacity to locate ourselves within that narrative – to be able to say 'this is *my* story' – are crucial to the emergence of the sense of 'self' Harré (1998) refers to as Self 2 – "the totality of attributes both ephemeral and enduring of the person I am" (Harré, 1998, p. 148) . It is this sense of self Meares (2000, p. 26) refers to as the 'self as stream of consciousness'; the 'self' experienced as "a constantly changing fabric of inner experience, a kind of gossamer or 'shimmer' . . . " (Meares, 2000, p 10).

Central to the development of inner speech, suggests Meares (2000), are the child's experiences of symbolic play, which begins during the second year of life (Belsky & Most, 1981; Bornstein & O'Reilly, 1993; Fein, 1981; Tamis, LeMonda & Bornstein, 1995; Tamis-LeMonda, Damast & Bornstein, 1994, Ungerer, Zelazo, Kearsley & O'Leary, 1981, cited in Damast, Tamis-LeMonda, & Bornstein, 1996). As has already been outlined above, while engaged in such play children frequently talk out loud in a way that is "qualitatively different from that used for communication and ordinary coping with the environment" (Meares, 2000, p. 25).

As has also been noted above, Meares (2000) suggests that while chattering in this way the child "is in a state which is embryonically 'inner', similar to an adult who is lost in thought". Vygotsky's (1962) empirical research suggests that as the child grows older this chatter 'internalises' into 'inner speech' and becomes, essentially, "the language of inner life . . . the language of the self" (Meares, 2000, p. 26). At this new stage of development, suggests Meares (2000), the two ways in which a child uses language, 'linear' (directed outwards at the social world) and 'non-linear' (directed 'inwards'), become coordinated and ordinary conversation is made up of a combination of both of them.

The 'play-space', now internalised as the 'self', suggests Meares (2000, p. 26) "is now very much a metaphoric field arising, as it were, between people. Self is not only 'inner' but is found or at least manifest, in this metaphoric space", an insight which reflects Harré and Shotter's position that the 'self', and indeed all other 'psychological'

phenomena, exist within the "contingent flow of continuous communicative interaction between human beings" (Shotter, 1993a, p. 7). 'Myself', suggests Meares (2000, p. 26), "involves not only a sense of inner experience but also the movements of this experience going on between 'me' and other people. 'Myself' is 'in' and 'between'".

Thus, symbolic play does not spontaneously arise from within the child; rather, it is modelled and scaffolded by the mother and other significant people in the child's life, thus illustrating one of Vygotksy's central points that during development there is "a transfer of the control of action from one individual to another" (Lock, 1981, p. 29), with the location of the 'me' now shifting from the mother to the child due to the child's increasing ability to use symbols, in particular 'linguistic signs' (Lock, 1981) to communicate with others and with themselves.

This process begins, as has been noted above, with mothers showing their infant "what he or she feels like" (Meares, 2000, pp. 84-85) by reflecting their actions and facial expressions back to them during interactive play. Because of this the sense of 'inner life' or self as 'stream of consciousness' that emerges from symbolic play "includes the sense of the presence of the other, who is represented not as a single person but as a form of relatedness" (Meares, 2000, p. 26).

For both Harré (1998) and Meares (2000), the second and third ontological skills necessary for the emergence of those aspects of our subjectivity conceptualised as 'Self 2' are essentially the skills involved in autobiographical memory – the ability to construct a coherent narrative about past events, and the self-reflective capacity to locate ourselves within that narrative; to be able to say 'this is *my* story'. Indeed Meares (2000, p. 39) suggests that such storytelling "holds together the sense and feeling of an individual life". For Harré (1998, p. 135) such autobiographical telling is "the story of one's Self 2, a set of beliefs, offered to oneself and/or to others, at some moment in one's life. As such it is itself part of one's Self 2".

When this 'autobiography' is offered to others, however, it is also part of the production of what Harré (1998) has called Self 3, a "self which can exist in its recognition by relevant others". The expression of Self 2, what kind of person someone is, occurs in the display of Self 3. Thus the ability to tell stories about one's life, to oneself and to others, is central to the sense of 'self' as 'myself', and to the achievement of what Harré (1984a) calls personal being – our sense of ourselves as a singular being with a continuous and unique history, a capacity for self-reference ('self' consciousness), and the power of decision and action over our lives.

Autobiographic narratives involve more than just recounting facts about the past. They involve, as William James (James, 1890, Vol II, cited in Meares, 2000) pointed out, the additional consciousness that the past that is being recounted is *my* past. In other words, notes James (James, 1890, Vol II, pp. 649, cited in Meares, 2000, p. 35)

> I must think that I directly experienced its occurrence. It must have that 'warmth and intimacy' [which characterise] all experiences 'appropriated' by the thinker as his own.

Harré (1998, p. 136) suggests that the link that makes all the possible stories one could tell about one's life '*my* stories' is essentially our embodied selves and that the "grammatical devices for expressing one's sense of oneself, as one and only one person [Self 1], define the frame in which the discourses of self make sense" (Harré, 1998, p. 137).

Harré (1998, p. 137) goes on to note that

> [a]s human beings are located in time, that is their lives are sequences of events embedded in other sequences of events, the use of 'I' as narrator of a life indexes events as belonging in that continuous life course. My sense of myself is not as the locus of an event among events, but as the locus of a trajectory in a larger history.

Meares (2000) makes the same point when he notes that the pronoun 'I' shapes an individual reality despite that reality being in a state of ceaseless change. "The 'I' is a constant" says Meares (2000, p. 11) "offering a means of unifying personal existence".

As Harré (1998) points out, children learn how to remember and to 'tell' their lives in the same way as they learn to do everything else, through discursive interactions with other human beings in their social world. Harré (1998, p. 143) suggests that "at some point in development 'remembering' as a cognitive skill would have been in the 'zone of proximal development' and he draws attention to the work of Middleton and Edwards (1990, cited in Harré, 1998) on kinds of interactions between mothers and their children that result in the development of the ability to 'remember'.

Middleton and Edwards (cited in Harré, 1998) suggest that it is within certain conversations that children acquire the skill of establishing their own past as a discursive competence. It is within these interactions that notions like 'my memories' and 'my past' are developed. Harré (1998, p. 144) cites a transcript of a brief segment of one such conversation:

Mother: oh look / there's where we went to the riding stables wasn't it?

Paul: yeh / er er

Mother: you were trying to reach up and stroke that horse

Paul: Where? [laughs]

Mother: You don't look very happy though

Paul: Because I thought I was going to fall off

As Middleton & Edwards (1990, p. 39, cited in Harré, 1998, p. 144) point out, such conversations

> are used by parents as opportunities for marking past events as significant, recalling children's reactions and relationships, cueing the children to remember them, providing descriptions in terms of which those rememberings could be couched and providing all sorts of contextual reminiscences.

As these authors note, such studies suggest "the plausibility of a dialogical basis for thought . . . for an origin of self-consciousness, metacognitive and rationalized remembering, from within communicative pragmatics – from within children's conversations and arguments" (Middleton & Edwards, 1990, p. 39, cited in Harré, 1998, p. 144).

This suggestion is given further support by research[27] showing that

> by the middle of the third year of life, a child has already begun to join caregivers in mutually constructed tales woven from their real-life events and imagining. The richness of self-knowledge and autobiographical narratives appears to be mediated by the interpersonal dialogues in which caregivers co-construct narratives about external events and the internal subjective experiences of the characters.
>
> (Siegel, 1999, p. 36)

As Siegel (1999) points out, research suggests 'autonoetic[28]' ('self knowing') consciousness, the reflective capacity so central to the sense of oneself as a unified 'self' with a past, a present and a future, is also enhanced by communication with parents and other significant adults. This ability, as Siegel (1999, p. 36) points out, was thought until recently to be "wholly dependent upon the maturation of the frontal cortical regions of the brain".

[27] See Siegel (1999) for an overview of this research.
[28] To have "a sense of recollection of the self at a particular time in the past, awareness of the self in the lived present, and projections of the self into the imagined future" (Siegel, 1999, p. 35)

Such research supports "the general principle that interpersonal experiences appear to have a direct effect on the development of explicit memory[29]" (Siegel, 1999, p. 45) with conversations between parents and children before, during and/or after an event organising and integrating their experience and thus facilitating their remembering of that event. Research also shows that children who have more experiences of talking about their memories with their parents are able to recall more details about their lives later on (Bauer & Wewerka, 1995, cited in Siegel, 1999).

This suggests, notes Billig (1999, p. 157), that parents, in talking with their children about past events, "convey to them what is 'memorable' – in other words, what features are appropriate to recall". As Billig (1999, p. 157) further notes, parents will often ask guiding questions to prompt their children to provide appropriate responses, thus providing "discursive guides for what cognitive psychologists call 'retrieval cues'".

Billig (1999, p. 157) suggests that in doing this "adult speakers are demonstrating to children how to 'interrogate' the past". From those around them, children acquire kinds of narrative skills they require for remembering. These skills, suggests Billig (1999. p. 157),

> involve not merely the retelling of past events but also the construction of the narratives themselves. Consequently, children learn to retain memories by formulating them as narratives. The child practices these skills of remembering in the course of conversations with adults, with the result that the remembering is frequently not accomplished by the child alone but jointly with the adult. This practice of remembering in conversation continues throughout life.

Through this process children learn to apply the kind of questions their parents use to guide their remembering to their own individual reminiscing and, as Billig (1999, p. 158) notes, "external dialogical skills, having been internalized as inner speech, become a means of constructing memories". As Billig (1999, p. 158) concludes, "the skills of explicit remembering are bound up with the skills of language and, therefore, they are learnt skills".

Thus, via such processes even our innermost sense of our 'self', our 'self' as 'stream of consciousness', is constituted out of the continuous coactions between us and

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[29] Explicit memory is when a person is aware they are remembering something. Implicit memory is when we are not aware that we have remembered anything. Implicit remembering can occur from birth, as evidenced in the way infants learn to recognize the faces and voices of loved ones, as well as various other sights and sounds, patterns of movement, etc. Implicit remembering can also occur in non-human animals whose behaviour can be changed by experience. In explicit remembering, however, language is typically involved.

our social world. Our sense of 'self' emerges from our earliest interactions with significant adults in our lives as they scaffold and facilitate our play and, later, as they scaffold and facilitate our 'rememberings' and our abilities to claim those rememberings as our own.

Meares (2000) further suggests that not only our sense of 'self' but also the value we assign to that self, emerges out of these early social interactions. For Meares (2000) the concept of 'value' in this context is essentially the feeling tone that permeates a person's experience of life. It is the 'feeling tone', suggests Meares (2000, p. 65),

> which gives the individual his or her sense of his or her value. A feeling of well-being, of feeling good, is the source of self-esteem. This feeling, which is a particular kind of pleasure, is often only a background experience. It arises through a resonance between one's core experience, the essence of one's immediate personal reality, and the responses of others.

This kind of resonance, suggests Meares (2000), is central to the proto-conversation, as outlined in Section 3.3.1 above, that occurs between a mother and her infant and "involves a fine co-ordination between the facial expressions, vocalisations and body movements of mother and child such that they can be conceived as a single system made up of two people" (Meares, 2000, p. 68). "The particular form of pleasure upon which value depends", suggests Meares (2000, p. 68), "arises as a consequence of caregivers' responses which create a feeling of 'fit' with the immediate experience of the baby". Pleasure does not just arise from within the baby, rather it is "engendered by the harmonious connectedness between the baby's state" and the state of those with whom s/he is interacting, at this stage usually the mother (Meares, 2000, p. 69).

Meares (2000, p. 69) suggests that "as the child grows older, his or her core experiences will require more sensitive and imaginative resonance". This becomes particularly important when the child begins to develop that aspect of the sense of 'self' which is experienced as an 'inner life' or 'stream of consciousness'. Meares (2000, p. 69) suggests that the responses of a caregiver to a child, "in that they represent in the outer world the essentials of the child's experience, are a re-knowing, a re-cognition of the child's experience".

Meares (2000, p 69) goes on to suggest that the pleasure that this recognition elicits depends "upon a matching process which is essential to our ordinary coping with the environment". Changes in the surrounding environment, suggests Meares (2000),

even very small ones, cause a change in that matching judgement from familiar to non-familiar. As Meares (2000, p. 69) points out, by way of example

> [w]e pick up cups, turn door handles, walk up stairs, taking little notice of what we do. If, however, the cup seems unusually heavy, the door handle turns too far, or our footfall on one of the stairs sounds different from the rest, our attention is aroused

If this feeling of unfamiliarity continues to increase the arousal shifts into anxiety and a feeling of insecurity. Meares (2000) suggests that the kind of pleasure which generates feelings of value comes from events in the environment which match the individual's expectations, expectations which themselves have been generated by previous experiences. This matching, Meares (2000, p. 69) suggests,

> is of a very particular kind. It involves a resonation with what is known of oneself, however dim or tenuously formed this knowing may be. Pleasure arises when the responses of the other show a re-cognition of our personal reality.

This may not necessarily be the 'reality' that the person shows to the world (Harré's 'Self 3'). The resonance is with "that complex of feelings, imaginings, memories, which is seen as the core of individual existence", the private aspect of Harré's (1998) 'Self 2' that Meares (2000, p. 70) calls 'myself'. Meares (2000) suggests that this recognition of our personal reality on the part of significant others in our social world is an essential part of our development and if "such recognition is not habitually given, or when it is, repeatedly, a misrecognition, the child suffers developmental damage" (Meares, 2000, p. 71).

Thus, Meares (2000) is suggesting that a central aspect of Self 2, our self-concept – which essentially encompasses all those things we believe about ourselves, in particular the beliefs we have about the value of our Self 2 – is fundamentally shaped by our very early social interactions, the most significant of which are those with our primary care-giver. And because the things we believe about ourselves, and the value we place on ourselves will inevitably impact on the way in which we present that self, both purposely and accidentally, to others in our social world these early social interactions will also shape our Self 3.

3.3. ACCOUNTING FOR THE 'SELF' WHO IS 'NOT MYSELF' WITHIN A SOCIAL CONSTRUCTIONIST FRAMEWORK

I have suggested that a social constructionist approach of how persons and their selves emerge may provide insights into the discursive origins of our sense of 'self' which may, in turn, lead to new understandings of the various kinds of suffering we call 'mental illness'. One central aspect of our experience is left essentially unaccounted for by such an analysis, however; the unconscious[30] aspects of human psychology. What of the 'self' who feels 'driven' by unexplained urges, desires, aversions and fears? The 'self' who cannot understand its own actions, the self who wants to act one way and yet acts in another? The self who is 'not myself'?

Because this sense of not being in control of one's own self is so central to many of the experiences conceptualised as 'mental illnesses' – as has already been noted above, it is often the 'self' which is characterised as being 'disrupted', 'split' or 'lost' when people suffer from these 'illnesses' (Lally, 1989; Karp, 1996; Estroff, 1989) and people who experience such suffering often note that in the midst of it they were 'not myself' (Estroff, 1989; Lally, 1989) – it is important to discuss how such experiences can be accounted for within a social constructionist framework.

It is suggested that this aspect of our being in the world can be fully accounted for within a social constructionist framework, but only when it is acknowledged that such experiences (a) belong primarily to that "realm of experience primarily constructed in and expressed through embodiment, rather than through language, and relatively resistant to translation into it" (Burr, 1999, p. 113) and (b) often have their roots within the system of social relations in general thus rendering their origins more psychologically obscure.

In this section I will bring both of these realities – our biophysical embodiment and the system of social relations within which we are embedded – to the forefront in an attempt to account for those aspects of our lives which are popularly conceptualised as 'unconscious' within an essentially social constructionist framework.

[30] In the context of this thesis I am using the word 'unconscious' simply as shorthand for those aspects of our lives that we do not feel to be under our control. I am not referring to the psychoanalytic unconscious.

3.3.3. The sociocultural constitution of forms and modes of embodiment

The failure of social constructionist and discursive theorists to fully engage with the reality of human embodiment has been pointed out by a number of critics (Burr, 1999; Cromby, 2004a; Cromby & Nightingale, 1999; Martin, 2003; Sampson, 1998) and indeed Harré (Harré, 1991, 1999) himself. As noted by Cromby (2004a, p. 798).

> The body tends either to be omitted from constructionism, or only to appear as surface of inscription, metaphor or text – rather than as a fleshy organ bearing both enablements and constraints.

Critics note that even for those social constructionists who acknowledge the reality and the importance of embodiment, as do Shotter and Harré, the biophysical grounding of human beings tends to play a relatively minor part in their theorising (Cromby, 2005; Martin, 2003). As Cromby and Nightingale (1999, p. 10) point out

> bodies are difficult to find in social constructionism, which tends to dismiss the body whilst simultaneously appearing to address it by providing detailed analysis of the discourses of bodily matters. Studies of discourse typically proceed as though their raw material was not already the product of embodied beings, in seeming ignorance of the fact that talking is not the only form of interaction. In continually either ignoring the body or treating it as a mere metaphor or text, social constructionism obscures and downplays the significance of its functional, physiological, hormonal, anatomical and phenomenological aspects.

Cromby (2004c, p. 2) notes that "the omission of . . . embodiment creates particular problems for critical accounts of psychopathology, which must then proceed as though their focus was simply a discursive form in the DSM, or an iatrogenic arrangement of administrative-bureaucratic-technical practices aimed at 'symptoms' that were somehow immaterial before those very practices created them". Cromby (2004c, p. 2) goes on to note that "this creates a conceptual space where individualised biomedical explanations can thrive since their explanatory force . . . can appear greater by contrast with accounts that disregard the embodied character of distress".

Thus, although the social constructionist perspective removes many misconceptions about people and their relationship to the social world inherent in mainstream psychology and psychiatry this approach to understanding human 'psychology' can still provide only a partial picture of psychological suffering due to its failure to fully acknowledge embodiment.

A person is a socio-culturally and biologically co-constituted organism. As Smail (1993, p. 62) points out "a person only comes into being when a body is placed in a social world which interacts with it". Psychological suffering, like all other human behaviours, capacities and experiences, cannot be understood by attempting to reduce it to its sociocultural origins, as a lot of social constructionist theorising does. Nor, of course, can it be understood by reducing it to its biophysical origins, as bioreductionist psychiatry does[31].

The importance of acknowledging the reality of our embodiment is highlighted by the findings emanating from recent research in neuroscience. As Schore (2001a, p. 2) points out, this research focuses not just on "sensory, motor and cognitive development, but on the development of the child's adaptive social and emotional functions" and emphasises

> that the development of the infant's emotional brain is directly and actively influenced by his [sic] transactions with the animate social, and not the inanimate physical environment.

As this research makes clear, not only does our sociocultural enmeshment result in us becoming 'persons' with 'minds' it also impacts directly on our physical being. The very structure of our brains and nervous systems are shaped by our experiences in the social world[32]. The impacts of the social world upon our bodies then, of course, often effect the ways in which we engage with the social world. Thus, complex feedback loops are created which can precipitate, protect against, exacerbate or alleviate psychological suffering.

In an attempt to bring the embodied feeling/experiencing person to the forefront of this account, I will now turn to the theorising of John Cromby (2005; 2006b). Cromby regards the body as the origin of experience and draws on the theorising of Norbert Elias, Pierre Bourdieu and also on the later work of John Shotter to begin developing an appropriate notion of embodied subjectivity within a social constructionist framework.

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[31] Neither can it be reduced to the psychological (e.g., unconscious drives or mental mechanisms) as often occurs in the metaphorical DMA where the causal drivers for many 'mental illnesses' are posited to be 'psychological'.

[32] This process can also, of course, flow in the opposite direction, with the structure of our brains and nervous systems shaping or our experiences in the social world. This is the position of biological psychiatrists – dysfunctional body/brain --- dysfunctional 'mind'/person. As will be discussed in Section III this very simplistic linear-causal position takes no account of the complex coactions that occur between the embodied organism/person and the social and material world within which they are enmeshed.

For Cromby (2006b, p. 13) our embodied feelings "are the core stuff of human experience" and, as such, must be acknowledged within social constructionism if it is to provide us with the fullest account of what it is to be a person in this world. As Cromby notes, citing the work of neuroscientist Antonio Damasio (1999, cited in Cromby, 2006b), in neural terms our embodied sensations or feelings are "the fundamental fabric of consciousness: deprive the brain of all physical feedback from the body, and consciousness also disappears". Thus, as Cromby (2006b, p. 13) notes, "[t]he moment by moment flow of our experience consists, before it consists of anything else, of a flow of embodied sensations or feelings". "To be a person", suggests Cromby (2006b, p. 13) "is first and foremost to be a feeling body".

Cromby (2006b) notes that embodied 'feelings' include not just those feelings we would call 'emotions'. 'Feelings' encompass a far wider class of experiences such as being hungry, thirsty, tired, lustful or in pain and also those "half-recognised, inarticulate feelings, that arise fleetingly in social interaction and which lead us afterwards to say things like 'well, it just felt wrong'" (Cromby, 2006b, p. 13).

All these 'feelings', while embodied, are, as Cromby (Cromby, 2006b, p. 13) points out, "nevertheless thoroughly socialised" as research in neuroscience (Damasio, 1994), psychology (Shotter, 1993b) psychiatry (Perry, 1991; Wexler, 2006) and various social sciences (Shweder, 2004, cited in Bourdieu, 1977; Cromby, 2006b; Elias, 1982) shows. Cromby (2005) begins the task of theorising embodied subjectivity by looking at the work of two social theorists whose focus has been the sociocultural constitution of forms and modes of embodiment; Norbert Elias and Pierre Bourdieu.

As Cromby (2005) notes, Elias (1982) outlines a history which shows that the civilising process Europe went through as it emerged from the Medieval period was essentially

> a temporary monopolisation of the means of violence in the hands of police and other agents of the state, a moment within an ongoing competition for power where certain practices are seen as the rightful perogative of some sectors of society and not others. It is the dynamic, unstable, and temporary solidification of a somewhat fragile power relationship, not a permanent consensus of liberal tolerance and consolidation of human rights.

In his analyses Elias (1982) uses the notion of 'figuration' – a concept that "indicates the way in which humans within a group or a society are bound by mutual dependence on each other" (Burkitt, 1991, p. 164). This dependence occurs not just between allies, but also between opponents. For Elias (1982), as Burkitt (1991, p. 165)

points out, "our actions are always tied to, and limited by, the actions of all those with whom we are interdependent".

Thus, as Burkitt (1991, p. 166) notes,

> individuals can never be treated as separate from their societies, because from the moment we are born we are always in a figuration of interdependencies with other people. The figuration is therefore the unit of analysis, and it is only within it that the different perspectives of 'I' and 'we' – the individual and the group as a whole – develop.

'I' and 'we' are not pre-given entities, for Elias, "but reference points within a figuration. They indicate the positions held by people in their relationships to one another" (Burkitt, 1991, p. 166). Like Shotter and Harré, Elias is aware that experiencing oneself as an 'I' can only develop in conjunction with the recognition of the separateness of others.

As Cromby (2005, p. 138) notes, "the management and embodied expression of power within specific figurations" includes things like the way in which people greet one another, the learning of the correct etiquette (e.g., ways of eating and behaving) for various public situations. According to Cromby (Cromby, 2005, p. 1388), "these bodily expressions accompany and exemplify channelised forms of feeling and thinking, modes which reflect and enact social forms and are 'embodiments of a . . . mental and emotional structure'" (Elias, 1978b, p. 56, cited in Cromby, 2005).

For Elias (1982), as Cromby (2005, p. 138) points out, embodiment includes not only the management of posture, gesture and expression, but also has a phenomenological dimension; "modes of subjectivity, individual repertoires of thinking and feeling . . . [are] simultaneously societally induced through enculturation". Thus people's status, location, and their "specific trajectories within particular matrices of figurations" will, according to Cromby (2005, p. 138), "generate distinct and different modes of being – but these differences are themselves societal products".

Elias's (1982) work suggests that there is no such thing as an unchanging 'human nature'. Rather, as Burkitt (1991, p. 174) points out, "what Elias wants us to contemplate is the entire restructuring of the personality and the psychic economy in the process of historical change". The personality is formed within the social process, or what Elias (using a term common to Bourdieu) refers to as the 'social habitus'. For Elias (in Goudsblom & Mennell, 1998, p. 73, cited in Cromby, 2005, p. 139) the whole structure of someone's personality "both conscious and unconscious is a product of interweaving

formed in a continuous interplay of relationships to other people and that the individual form of the adult is a society-specific form".

The other theorist whose work Cromby (2005) suggests may helpful for theorising embodied subjectivity within a social constructionist framework is French sociologist Pierre Bourdieu (1977). For Bourdieu our 'dispositions' or 'lasting ways of being' "are organised into structured and structuring systems" he calls the habitus (a term used in common with Elias to designate a similar phenomenon). Habitus is defined by Bourdieu and Wacquant (1992, p. 16, cited in Sampson, 1998) as "a set of historical relations 'deposited' within individual bodies in the form of mental and corporeal schemata of perception, appreciation and action".

As Burkitt (1991, p. 133) points out, different groups and classes within a society will have a different habitus and this will predispose them "towards specific types of practices and the development of particular life styles". Sampson (1998, p. 25), a social constructionist who, like Cromby (2005), utilises Bourdieu's theorising to 're-embody' social constructionism, defines habitus as

> that aspect of our cultural learning that is deeply carved within our bodies, so deeply in fact, that it generates a kind of 'feel for the game' that describes a practical rather than a purely theoretical kind of knowledge.

Burkitt (1991) notes that as a child's capacities and skills are being developed within the kind of interactions with adults discussed in Section 3.3 above, we can also see the beginnings of the formation of the 'social habitus' – the basic dispositions fundamental to individuals within a particular social group or class. As Burkitt (1991, p.155) points out, this kind of learning begins before the child even develops language or a sense of individuated self.

> Dispositions and inclinations are formed in the earliest years through the child's interdependence with adults, which will later incline the person towards the development of certain capacities, and will orientate them within social practice as a whole. A repertoire of what Bourdieu calls 'strategies' will be passed on to the child which will enable or limit their social activities in later years . . . many of the dispositions and inclinations formed in the habitus from the earliest years of infancy may not be dialogically articulated as part of discursive consciousness, and will continue to operate within the personality as an unconscious force.
>
> (Burkitt, 1991, p. 155)

As Sampson (1998, p. 26) points out, the habitus "does not describe a transcendent entity outside either culture or history. Our bodies are rather fully socialized". Habitus/embodied discourse is essentially "those learnings and knowledges placed in our bodies by virtue of where and when we dwell" (Sampson, 1998, p. 26). As

Cromby (2005, p. 140) points out, "dispositions are related to individuals' location within dimensions such as gender and social class, and like Elias (1982), Bourdieu emphasises the role of early experience in their acquisition".

Ruling ideologies and subcultural norms are not just discursive constructions. Systems of dispositions inculcated by the habitus, according to Bourdieu (1977, p. 94) are "political mythology realised, *em-bodied*, turned into . . . a durable manner of standing, speaking, and thereby of *feeling* and *thinking*". As Cromby (2005, p. 140) points out, the habitus "instils within individuals patterns of dispositions which structure their embodied experience (in turn inciting them to reproduce its own structure), setting effective boundaries on the lived socio-cultural world". Thus, the habitus particular to the time, place and social class within which you are born becomes quite literally embodied as an array of likes and dislikes, which feel entirely personal to you.

As Cromby (2005) further notes, because they are embodied rather than consciously learned, such dispositions " are not readily amenable to transformation". As Bourdieu (1977, p. 94) puts it

> The principles em-bodied in this way are placed beyond the grasp of consciousness, and hence cannot be touched by voluntary, deliberate transformation, can't even be made explicit; nothing seems more ineffable, more incommunicable, more inimitable, and, therefore, more precious, than the values given body, made body by the transformation achieved by the hidden persuasion of an implicit pedagogy, capable of instilling a whole cosmology, an ethic, a metaphysic, a political philosophy, through injunctions as insignificant as 'stand up straight' or 'don't hold your knife in your left hand'.

Cromby (2005, p. 141) points out that for both Elias and Bourdieu "our embodiment is societally produced, reflecting both the culture we inhabit and our location within it". Although such a position can be read as deterministic

> these theorists are not describing behavioural certainties but modal tendencies . . . each highlights what we can call *somatic repertoires* that are typically, but not exclusively or deterministically associated with gender identities or class locations.
>
> (Cromby, 2005, p. 142, italics in original)

As Cromby (2005) notes, while the notion that feelings guide and shape our actions is embedded in our folk psychology it is rarely acknowledged by social constructionist / discursive psychologists. One theorist who does make this guidance via feelings central, however, is John Shotter (1993b), who in his later theorizing describes it as 'knowing of the third kind'. It is to Shotter's (1993b) work that Cromby

(2005) turns in order to further explore the possibilities of integrating the realities of our embodiment into a social constructionist account of human psychology.

For Shotter (1993b, pp. 40-41) feelings supply an "embodied form of practical-moral knowledge in terms of which people are able to influence each other in their being, rather than just their intellects". In this view the responses people have to an interaction or a relationship communicate themselves not just discursively but also within the embodied feelings we experience within that situation. Shotter (1993b, pp. 40-41) describes this knowledge as an 'affective attitude', a "transmuted version of a social relationship" lending our words and verbalised thoughts their "particular motives and valencies". These feelings include the emotions we can easily recognise such as love, anger and fear, but they also include other feelings which are more difficult to pin down.

Shotter (1993b), drawing on the work of Vygotsky, locates the origins of this 'knowing of the third kind' in the 'instructional' social relations which occur during the period of psychological symbiosis (discussed in Section 3.2.1 above). As Cromby (2005, p. 142) notes, for Shotter (Shotter, 1993b) this 'knowing of the third kind' appears phenomenologically as feelings which are "called out within streams of activity and [are] functional within them, supplying sensuous practical-moral guidance and 'rooting' our actions synchronously with others". Shotter's 'knowing of the third kind' meshes well with the notion of the habitus explicated by both Elias (1982) and Bourdieu (1977) which, as already noted above, refers to the aspect of our cultural learning which is literally 'em-bodied', generating a kind of 'feel for the game' as Shotter (1993b) refers to it, which reflects a primarily practical, rather than theoretical, knowledge.

For Shotter, as Cromby (2004c) points out, our subjectivity (essentially our 'personal being') is the outcome of the dynamic interaction between this 'knowing of the third kind' and a primarily discursive process he calls 'joint action'. For Shotter 'joint action' refers to the ways we use discourse to negotiate our interactions with each other (Cromby, 2004c). Shotter emphasises the open-ended nature of joint action, noting that it often produces outcomes unforeseen by its participants.

Thus, as Cromby (2004c) points out, for Shotter subjectivity, our sense of who and what we are, is made up of thoughts and feelings which arise from within our networks of social relationships. The responses of others, through talk and through extra-discursive means such as gestures, posture, tone of voice and facial expression, together with our own talk and our own gestures, posture, etc., continually create and

re-create the situations 'into which' we must act and through which our 'selves' are continuously formed and re-formed.

The implications of this for people living within societies where profound inequalities and injustices exist and occur, as Williams (1999, cited in Cromby (2004b)) notes, is that such inequalities become

> deeply embedded in our personal identities. Therefore, we should not be surprised when we find them difficult to speak about, and hard to change.

3.3.4. The primacy of the 'feeling body' in the social construction of the 'self

In several other papers Cromby (2004b; 2004c; 2006b), drawing on insights gained from the work of the theorists discussed above, explicates his own view of the centrality of this embodied subjectivity to our experience of being human. Utilising the work of neuroscientist Antonio Damasio (1999, cited in Cromby, 2004b), Cromby notes that "in neural terms, our experience of self is first and foremost the experience of being a body in a situation" (Cromby, 2004b, p. 16), an insight which accords with Harré's (1998, p. 4) point that a fundamental aspect of our sense of self, which he calls 'Self 1' is

> to have a sense of one's location as a person, in each of several arrays of other beings, relevant to personhood. It is to have a sense of one's point of view . . . a location in space from which one perceives and acts upon the world. . . including the part that lies within one's own skin.

According to Damasio (1999, cited in Cromby, 2004b, p. 2) our 'core consciousness', "the fleeting point of awareness that constitutes our very being as engaged, aware and active beings, is consciousness of our embodied state". Such 'core consciousness' is, suggests Damasio (1999, cited in Cromby, 2004b, p. 2) "generated or renewed in 'pulses' . . . whenever something new impinges upon us and, however minimally, changes the state of the body-brain system". Such state-changes can also come from our own bodily processes. Thus, notes (Cromby, 2004b, p. 3), while we are awake

> core consciousness is continually renewed by the incessant flow of changes in our bodies and brains. Core consciousness is fleeting, transient, and ephemeral. Its content is of a body in a situation right now, seeing, hearing or feeling something – but the full meaning of these things only emerges (very shortly) afterwards.

Damasio (1999, cited in Cromby, 2004b, 2004c) suggests that each time something impinges on our core consciousness this activates other areas of the cortex which then almost immediately provide us with the tools[33] required to attribute meaning to it. For example, a negative feeling state may be named as 'loneliness', due to us having learned, via our discursive interactions with others in our social world, to use the word 'loneliness' to name that feeling, and it may be understood as being due to the recent end of an important relationship. Damasio (1999, cited in Cromby 2004b) calls this "web of meanings and interpretations that we then create 'extended consciousness'" (Cromby, 2004b, p 16). Our ability to use language then "allows us to narrate richly-detailed meanings within our lives" (Cromby, 2004b, p. 16).

This 'narration' essentially comprises those aspects of the self Harré (1998) characterises as Self 2 (encompassing the "ephemeral flows of activity, both private and public, in which that person engages, producing thoughts and actions sometimes but not always displaying repeated structures and forms" (Harré, 1998, p. 135) and Self 3 – "the impression of a person's personal characteristics that one person makes on another" (Harré, 1998, p. 4), both intentionally and unintentionally.

As Cromby (2004b) points out, Damasio (1994, cited in Cromby, 2004b), echoing the theorising of Elias and Bourdieu discussed above, also proposes that "how we feel, our experience of our bodies, is not simply a matter of biology: our feelings themselves are also . . . socialised, structured by experience" (Cromby, 2004b, p. 16). As Cromby (2004b, p. 16) notes, "memories . . . do not only take the form of images, sounds or tastes; they also take the form of feeling, body state profiles". Thus, when we experience something, for example, being let down by someone, feelings that in the past were associated with similar experiences are "called out by feedback loops between brain and body" (Cromby, 2004c, p. 3). Such feelings tag future experiences with positive or negative valences.

Damasio (1994, cited in Cromby, 2004c) calls such re-constituted feelings 'somatic markers' and, as Cromby (2004c) points out, his "work with brain injured people suggests they play a vital role in decision-making, especially in social settings". These 'somatic markers' influence the way we make decisions by rendering some options more attractive, or by directing our attention away from other, less favourable options. These 'somatic markers' "may introduce patterns of bias and apparent irrationality into our

[33] This corresponds to Harre's (1999; 2002) 'tools/tasks' analogy as outlined in Chapter Five, Section 5.2.2.

actions, patterns which we ourselves might only notice retrospectively", if we notice them at all (Cromby, 2004c, p. 4).

These 'somatic markers' may have their origins in our pasts, "but their influence stretches forwards into the future because they structure the viable possibilities we perceive, and so influence the choices we make" (Cromby, 2004c, p. 4). Such 'somatic markers' are the literal embodiment of the 'validations' (Harré & Gillett, 1994) operating within the discursive contexts within which people are enmeshed (see Section 3.2.1).

Thus, according to Cromby (2006b) the feelings which constitute our subjectivity provide us with a constant 'automatic' sense of our bodies (whether we are comfortable or uncomfortable, hot or cold, hungry or sated); they bias us toward goals depending on our bodily states (e.g., we are tired, we want to sleep; we are hungry, we want to eat), what has occurred to us previously (we are more likely to avoid a situation which 'felt bad' in the past), and broad patterns of socialisation (people do things which 'feel right' according to cultural and sub-cultural norms). This last is, of course, the effect of the habitus as outlined by Bourdieu and Elias – "those learnings and knowledges placed in our bodies by virtue of where and when we dwell" (Sampson, 1998, p. 26) or, to put it in Shotter's (1993) terms, our 'knowing of the third kind'.

Cromby (2006b) suggests that it is not language, in the form of inner speech, which is the primary element of subjective experience. For Cromby (2006b) feelings are not 'cognitive', rather they are "the pre-cognitive, unreflective ground upon which information processing, 'rational' choosing and decision making occur". Feelings can be taken into account and decisions made accordingly but, as Cromby (2006b, p. 14) points out, "whether we recognise their influence or not, feelings are always present: shaping our goals, biasing our evaluations, and guiding our attention".

These embodied feelings are there from the very beginning, long before we develop a facility with language, and they remain at the core of our experience throughout our lives. It is such feelings, rather than language, which are central to the "affective exchanges" (Shotter, 1984, p. 57) between a mother and a child in the very early stages of their relationship. As was pointed out in Section 3.2.1 above, "the sort of perception involved in these exchanges – of the expression of feeling or affect – is very primitive" (Shotter, 1984, p. 57), with the participants acting purely as natural agents or 'biological individuals'.

This centrality of feelings to our subjective experience is evident, as Meares (2000) points out, in our memories of our own past. While one may remember what

schools one attended, and in what years, central to autobiographical memory is the sense of a personally experienced past. As Meares (2000) points out, such remembering is

> made up of episodes of personal experience that have a sensory aliveness. The stereotypic episode has onself at its centre and is made up of sights, sounds, smells and the feeling of one's body.

Cromby (2006b)points out, however, that claiming socialised embodied feelings constitute the core of subjectivity does not deny the importance of inner speech (that sense of our selves Meares (2000) calls 'myself' or 'self as stream of consciousness'). The point, suggests Cromby (2006b, p. 14) "is that inner speech typically comes *afterwards*, and is not the primary force shaping our activity".

Cromby (2006b) suggests that there is a considerable amount of evidence to support this suggestion, and that drawing on this evidence "renegade cognitive psychologists like Zajonc have argued for versions of affective primacy, as have most psychodynamic theorists" (Cromby, 2006b, p. 14). Cromby (2006b) further notes that studies of people's discourse (Edwards & Potter, 1992) have also suggested that inner speech is secondary to our socialised embodied feelings by showing "that what people say is situated and occasioned in orientation to their current social sitution rather then being the simple expression of an 'inner' decision-making process" (Cromby, 2006b, p. 14).

Cromby (2006, p. 14, author's italics) notes that such evidence suggests that

> there is a kind of primacy to feelings, and that inner speech functions to make sense of them, relate them to things that are going on: to *fix* them, if you will, such that we can represent them to ourselves and *know*, in a thoroughly human sense, what our feelings mean.

As Cromby (2006b) points out we use our inner speech to make sense of our feelings and because what we tend to remember of situations is our interpretation of them this gives a sense of primacy to inner speech. As was noted above, it is the primacy accorded to 'inner speech' which helps to create the impression that our motivations arise from 'within' us, rather than being the outcome of activity, our own and that of others with whom we interact both directly and indirectly.

The sense that inner speech is primary, argues Cromby (2006b, p. 14), is illusory because "inner speech functions to *complete* feelings, which always come first". This, of course, does not mean that inner speech has no influence. Our inner speech constitutes

an almost constant dialogue we hold with 'ourselves' and we use it to facilitate our decision-making (will I have that extra slice of chocolate cake?), help us to understand and deal with difficult situations (he seemed angry at me, but perhaps he was just tired), help us decide what to do/say (should I stay and be honest with him, or should I go and stay quiet?), etc..

As Cromby (2006b) points out, however, when inner speech guides our actions in these ways "it does so by calling out further, alternate states of feeling". Essentially, things happen which evoke feelings and we name these feelings with inner speech. This inner speech can then evoke more feelings, which in turn will lead to further commentary, and more feelings, and so it goes on. Thus, "there is a constant iteration between socialised feelings and socially derived inner speech, a dialectical relationship, a ceaseless flux of fluid movment from one to the other" (Cromby, 2006b, p. 14). Because language is primarily representational, however, our thoughts and our memories tend to emphasise the words which are relevant to how we are feeling/acting rather than the nameless feelings that preceded them (Cromby, 2006b).

Cromby (2006) points out that it is the ability of words to create or 'call out' feelings and to guide or channel feelings so that we then act upon them, or relate to them in a particular way, that makes it easy to imagine it is language which makes us do what we do. Despite the huge significance of language in our experience of being a person, however, "the real primacy lies with feelings" (Cromby, 2006b, p. 15).

> feelings are how our primordial being-in-the-world is disclosed: both as habitual embodied intentional stances (which psychologists usually refer to using such constructs as 'beliefs'), and also momentarily, in the here-and-now, in our immediate pre-cognitive responses to things that happen, the events that occur and the situations we encounter.
> (Cromby, 2006b, p. 15)

This is not to say that our socialised feelings locate us simply and unproblematically in our worlds because "our fully human sense of our selves only emerges from their dialectical interaction with language (relationally and as inner speech)" (Cromby, 2006b, p. 15), as was outlined in Section 3.2 above. As Cromby (2006b) points out, feelings can sometimes be extremely difficult to put into words due to their fundamentally non-verbal character and even if we could verbalise feelings successfully often we are completely unaware of their sources. If we fail to notice what prompted a feeling we may interpret it incorrectly. Also, we often have good reasons not

to acknowledge our feelings, for to do so may open up possibilities which we may find difficult to contemplate.

Cromby (2006b, p 15) suggests that this means that the view from the "fleeting point of 'rational' reflection that is 'I' is always somewhat limited". There are too many influences which go together to create our present for us to be aware of them all. Some of these influences will be there in our immediate situation, others will result from the general social structure within which we are living our lives, and others will be chronologically distant or "subtended by neural mechanisms that operate out of conscious awareness" (Cromby, 2006b, p. 15), as will be discussed in Chapter Four.

As Cromby (2006b, p. 15, author's italics) points out, in agreement with the general social constructionist / discursive position explicated above

> we are, in fact, making our *selves* up as we go along, spinning out narrative constructions to fix our experiences, to render them coherent, sensible, morally acceptable, and rationally accountable to ourselves and others, according to prevailing subcultural norms.

For Cromby (2006b), however, as for Shotter (Shotter, 1993b), our selves are not only constructed through our emeshment in the social world, they are, as Cromby (2006, p. 15, author's italics) puts it, also constructed

> in the embodied, material, socially situated flow of our being in the world. In this way, we are being made up by the experiences our narratives strive to fix, and this making up is more important and powerful than the retrospective ordering that narrative provides.

Because of this reality our selfhood is inevitably a somewhat fragile achievement and those whose early years did not provide them with sufficient protection from the blows that life inevitably deals to most of us know this "to the very core of their being" (Cromby, pp. 15-16). The implications of this for our conceptualisations of, and the way we respond to, the various types of psychological suffering we call 'mental illness' will be discussed in the remaining chapters of this thesis.

3.4. CONCLUSION

As noted in Section 3.1 above, if our complex, unique and privatised 'inner lives' (what Harré calls our 'personal being') are produced from our participation in the 'conversation' (in the extended sense) around us it is likely that the kinds of suffering

conceptualised as 'mental illness' emerge, at least in part, from the same source. It was suggested that if we could understand the genesis, and ongoing development, of our 'personal being' we may be able to come closer to some understanding of why the various problems we call 'mental illness' occur and begin to move towards a different way of conceptualising and 'managing' such suffering.

The approach to psychology advocated by the theorists whose work formed the primary focus of this chapter is the notion that to be human is "to be a growing system which can, in interaction with other growing systems, increasingly localize within itself the power of responsible action" (Shotter, 1984, p. 48). As Vygotsky's (1962) work makes very clear, "people can only gain their personal powers from 'nature', from the social ecology within which they are embedded" (Shotter, 1984, p 48).

Through the actions of other people, the things infants can at first only do spontaneously in response to circumstances are transformed, through another person's agency, into things they can do later of their own volition. Thus, as Shotter (1984, p. 71) notes, "the human child does not develop psychologically according to the 'laws of nature', but in an intentional manner". This means that "the concepts in terms of which we interact with our children play an important part in determining the form of their psychological development".

It is suggested that the picture of human beings sketched out in this chapter is more likely to provide the foundations of a theoretically coherent and practically useful account of psychologial suffering than the assumptions which, it has been argued, underlie the Dysfunctional Mind Account, as outlined in the Introduction.

CHAPTER FOUR

HUMAN BEINGS AS BIOLOGICAL ORGANISMS

4.1. INTRODUCTION

In Chapter Three it was suggested that in order to overcome the limitations of the Dysfunctional Mind Account it was necessary to provide an account that acknowledged the fundamental enmeshment of people within their social worlds. It was suggested the social constructionist / discursive view of human psychology may provide the foundations of a more theoretically coherent and practically useful account of psychological suffering and a social constructionist / discursive analysis of the emergence of selves, drawing on the work of John Shotter, Rom Harré and John Cromby was offered as a possible starting point for such an account.

The emergence of persons and their psychological suffering cannot be understood, however, by looking only at sociocultural/ discursive factors because persons are both socioculturally *and* biologically co-constituted. What is required, then, is an analysis of our biological development that would facilitate a clearer articulation of the ways in which this co-constitutional process occurs. It is suggested that such an analysis can be found in the work of developmental biologist Steven Rose (1997) who, in his book *Lifelines: Biology, Freedom, Determinism* acknowledges the complex interrelations between our bodies and the environments within which those bodies exist. In the following section a brief outline will be given of Rose's approach to biology in order to provide a framework for 'embodying' the social constructionist account of persons which will form the basis for the account of psychological suffering to be presented in this thesis by incorporating into it insights from biological research.

It should be noted at this point that in this section I will be primarily drawing on research from the biological sciences and in order to present this material as clearly and as straight-forwardly as possible I will present it in the same language in which it is

presented by the biologists and neuroscientists who carried out the research. This research, for all its often unjustified and unspoken assumptions about the kinds of creatures human beings are, leaves little room for doubt that what happens to us over the course of our lives profoundly shapes both our biology and our personal being. It is only by acknowledging this that any real understanding of psychological suffering can be reached.

4.2. LIFELINES: AN ALTERNATIVE VISION OF LIVING SYSTEMS

Steven Rose's (1997) work offers a view of biology that echoes many of the key motifs of Harré's social constructionist account of human psychology. Both approaches see human beings as products of the constant coactions[1] occurring between the organism and its physical/social world and argue there can be no real understanding of human beings if they are considered in isolation from their environment. Both approaches also stress the uniqueness of each individual and the non-determinate nature of their unfolding through development. As Rose (1997, p. 157) points out, "each of our presents is shaped by and can only be understood by our pasts, our personal, unique, developmental history as an organism".

While Harré and his fellow social constructionists focus on analysing the ways in which human psychological phenomenon such as 'minds' and 'selves' emerge from the coactions between a human being and their social world, Rose focuses on exploring how unique human beings emerge from the coactions between the biological organism and its environment (physical and social).

4.2.1. Organisms and their environments

As Rose (1997, p. 136) points out, "at the heart of modern biology lies the issue of the nature of individual living units – organisms". While Rose (1997) acknowledges

[1] A word used by Gottlieb (2002) to refer to the reciprocal interactions between various components of a dynamic system. These 'coactions' can be horizontal (.e., they occur at the same level – gene-gene, cell-cell, tissue-tissue, organism-organism) or vertical (i.e., they occur between different levels (gene-cytoplasm, cell-tissue, personal/psychological-nervous system).

there are a number of ambiguities inherent in our sense of the borders between ourselves and the external world, he notes, in agreement with Harré (1998), that "for most of the time we all have a sense of our own existence as a coherent whole, and we recognize such coherence and unity in others" (Rose, 1997, p. 136).

Rose (1997, p. 136) notes that organisms differ considerably in size but every organism "exists as a three-dimensional object occupying a defined volume within its environment, and each possesses recognizable structures, internal features and organization". As Rose (1997, p. 137) further notes, however, organisms extend in time as well as in space.

> Life persists not in three but in four dimensions – persistence which depends above all on the maintenance of order: order within the cell, order within the organism, order in the relationship of the organism to the world outside it.

Rose (1997) is also at pains to point out that genes and genomes do not contain the future of the organism. They are not, he insists, "like architects' blueprints or information theorists' code-bearers". Rather, "they are no more and no less than an essential part of the toolkit[2] with and by which organisms construct their own futures" (Rose, 1997, p. 137).

Rose (1997, p. 137) stresses that "neither cells nor organisms can be considered in isolation from their own external environments", just as Harré and his fellow social constructionists stress that psychological phenomena such as 'minds' and 'selves' cannot be usefully analysed in isolation from the social environment. As Rose (1997, pp. 137-138) points out,

> [a]ll cells are surrounded by membranes, constructed of complex arrays of lipid and protein molecules, which act as both barrier and interface with the world outside them. Across this semipermeable barrier there is a constant traffic with the cell's surroundings. To survive, let alone to act upon the external world or replicate, requires the continual expenditure of energy, energy derived from food in the form of pre-existing molecules such as sugars or fats . . . All these molecules must be carried into the cell across its membrane and waste metabolites ejected through it into the environment.

Rose (1997) further notes that for single-celled organisms the environment of the cell is, of course, also that of the organism. This environment is constantly changing. There may be plenty of food, or there may be very little. It may be too hot, too cold, too dry, too wet, or too acid. When faced with less than optimal conditions many single-celled organisms attempt to find more favourable environments. But, as Rose (1997)

[2] Rose's use of the word 'toolkit' in this context corresponds to Harré's notion of molecular and organismic tools being used for person-level tasks, as discussed in Chapter Five.

points out, their power to choose a better environment is inevitably limited by the range of environments immediately accessible to them, and to their ability to adapt to certain environments.

Rose (1997) then goes on to describe how, in difficult environments, cells can 'switch on' the DNA sequences which produce a new enzyme required to metabolize a food source they didn't previously need. As Rose (1997, p. 139) points out, this illustrates how "it is the organism in interaction with the environment . . . that determines which of its available genes are to be active at any one time".

The interactions between cells and their environments are, however, considerably more complex for multi-celled organisms. Individual cells are now surrounded by their own microenvironment, external to them but internal to the organism. It is the organism, rather than the cell, that must respond to environmental changes so as to optimise its chances of survival. Cells within organisms are buffered from external extremes and do not have to be searching for food in an uncertain environment. Thus their genes do not have to be ready to make the switch from one kind of food to another and they do not have to maintain a repertoire of DNA to enable them to make such a switch.

Thus the word 'environment' is very complex and multi-layered. The environment for individual gene-sized sequences of DNA is the rest of the genome and the cellular machinery in which it is embedded. For the cell the environment is the extra-cellular fluid within which it floats. For the organism the environment is the external physical and social world. No environment remains the same, notes Rose (1997, p. 140) – "change is virtually the only constancy. Stasis is death".

Rose (1997, p. 140) suggests there are two lessons to be learned from such descriptions. The first is that "boundaries between organism and environment are not fixed". Organisms absorb parts of their environment as food, and are constantly modifying their surroundings by excreting waste products into them or by modifying aspects of their world to suit their needs. As Rose (1997, p. 140) notes,

> [o]rganisms – any organism, even the seemingly simplest = and the environment – all relevant aspects of it – interpenetrate. Abstracting an organism from its environment, ignoring this dialectic of interpenetration, is a reductionist step which methodology may demand but which will always mislead.

The second lesson, according to Rose (1997, pp. 140-141), is that "organisms are not passive responders to their environments. They actively choose to change them, and work to that end . . . Organisms . . . are active players in their own futures".

4.2.2. Development: A process of being and becoming

As Rose (1997, p. 141) points out, the developmental process is quite different to the process involved in constructing artefacts. Rose (1997) gives the example of building a car – raw materials come onto the assembly line and piece by piece the car is built up. But it is only at the very end that a fully formed and fully functional car appears. The car, at its halfway stage, does not function 'in miniature'; indeed it does not function at all. Living organisms, however, from very early on in their development, "have to be capable simultaneously of quasi-independent existence, and of growing further toward maturity. Moreover, the attributes that enable them at any one moment to maintain their existence are not always merely 'miniature' forms of those they will need in adulthood" (Rose, 1997, p. 141).

This is particularly obvious in the case of organisms like frogs and butterflies but it is also true, in more subtle ways, for organisms that seem to have linear developmental trajectories devoid of radical breaks, such as human beings. As Rose (1997, p. 142, author's italics) notes

> when a newborn baby suckles at its mother's breast, the suckling reflex is not simply an undeveloped form of the chewing technique that will be needed when the child switches to solid food; quit different neural and mechanical processes are involved. Life demands of all of its form the ability simultaneously to *be* and to *become*.

Rose (1997, p. 142) suggests that the prevailing way of thinking about development always seeks to partition –

> first splitting 'nature' from 'nurture', and then adding them together again. So both being and becoming are regarded as the products of the additive effects of genes – nature – and 'environment' – nurture.

Rose (1997, p. 142, author's italics) suggests this dichotomy is spurious. Rather, "the unrolling processes of development are best understood in terms of a different dichotomy, that between *specificity* and *plasticity*".

These terms refer to the degree to which an ontogenetic process is modifiable by experience. Rose (1997) uses the human visual system as a way of illustrating these concepts in action. Humans, he notes, are born with their eyes open, they are able to focus them reasonably well and can see and perceive colours, shapes and movements. This suggests, notes Rose (1997), that the pattern of connections via which the light-sensitive cells of the retina connect to the brain must already be well established at birth.

But even in the visual system it is possible for the pattern of connections to be modified during certain critical developmental periods. The famous study by Blakemore and van Sluyters (1974, cited in Rose, 1997) in which cats were reared in environments of horizontal or vertical stripes, or with only one eye open, showed that such abnormal environments resulted in lasting changes in the patterns of synaptic connectivity. This, notes Rose (1997, p. 143), "is the measure of plasticity . . . which can be imposed upon developmental specificity". Both specificity and plasticity[3] are, however, embedded properties of the organism – "both are completely made possible by the genes, and completely made possible by the environment. They cannot be partitioned" (Rose, 1997, p. 143).

During development all the cells in the body must cooperate with each other if stability is to be maintained and each depends on the others to create and preserve "the dynamic pattern of connections which maps the world onto the sense organs, the sense organs onto the brain, and then, via the brain and the musculature, imposes new patterns on the world beyond" (Rose, 1997, pp 152-153). For Rose (1997, p. 153), development is "a constructivist process; the developing organism, in its being and becoming, in its specificity and its plasticity, constructs its own future".

As Rose (1997, p. 153) points out, however, even the constructivist model he maps out implies a degree of determinism, "albeit in this case a richer concept than the unidimensional gene". Rose (1997, p. 153) insists that if we are to understand development we need to go beyond this in "emphasising the role of chance, of contingency, at all levels of analysis of living systems". Rose (1997, p. 154) gives the example of identical twins who share identical DNA

> from the moment of conception and cell division the relative locations of the two embryos to the placenta and the environment of the uterus affect their development in

[3] It should be noted at this point that recent research has shown the human brain to be vastly more responsive to environmental input than was previously thought – this malleability of the brain is referred to as 'neural plasticity' (Huttenlocher, 2002, p. 9).

> chance ways. Developmental divergence increases with every cell division, and after birth with every random experience of each twin.

This is an insight that many studies attempting to determine whether 'mental illness' is 'caused' by 'nature' or 'nurture' (twin studies being an obvious example) fail to take account of. In the rush to credit the gene with all the determining power over how people develop, such studies often suggest that the 'environment' within which their subjects are being reared is essentially 'the same' (or 'different') thus completely missing subtle differences (or similarities) which may have as much power, perhaps even more, over developmental outcomes, as genes.

As the research to be discussed in the remainder of this chapter will make clear, genes do not play the lead role in development, rather they are 'designed' to work within an environment and to be 'used' by that environment. Genes are turned on and off by micro-environmental cues and these cues, in turn, are influenced by the experience of the individual. The implications of this insight for developing alternative understandings of psychological suffering will be discussed in more depth in Chapters Five and Six.

4.2.3. Living systems are dynamic systems

Rose (1997) argues that while homeostasis[4] has become one of the organising themes of physiology we must move beyond the concept of homeostasis to that of homeodynamics if we are to truly understand the lifelines of living organisms. As Rose (1997, p. 157) points out

> [t]he set points around which the moment-by-moment fluctuations in an individual's biochemistry oscillate on the microscale themselves change during the trajectory of a lifetime. Our body temperature, steroid hormone levels and neurotransmitter levels maintain diurnal rhythms.

Women of childbearing age experience monthly hormonal cycles that have been shown to significantly affect their patterns of life (Rose, 1997). Men may also show comparable changes, though as Rose (1997) notes, researchers have not thus far been particularly interested in pursuing this line of study. Lifelines, notes Rose (1997, p. 157)

[4] Homeostasis is the ability of a living organism to regulate its internal environment so as to maintain a stable, constant condition in the face of environmental fluctuations.

> are inherently homeodynamic. The present instant of ours or any organism's life, is simply inexplicable biologically if considered merely as a frozen moment of time, the mere sum, at that moment, of the differential expression of a hundred thousand genes. Each of our presents is shaped by and can only be understood by our pasts, our personal, unique, developmental history as an organism.

As Rose (1997) goes on to point out, even the moment-to-moment stability of an organism is maintained dynamically rather than statically. It is now known that life cycles are not a period of growth from conception to adulthood, then a long period of relative stasis and then finally a decline into old age and death. Each cell in the adult body has its own life cycle from mitosis to death within a few days, weeks or months. Even brain cells, which used to be considered permanently amitotic (i.e., they did not divide), can replace themselves when they die, although research is suggesting that they will only do this under certain conditions (Gould, 1997; Gould, Beylin, Tanapat, Reeves, & Shors, 1999).

Further, the life and death of any cell continues relatively independently of the life and death of the molecules of which it is composed. The complex macromolecules (proteins, nucleic acids, polysaccharides, lipids) that make up a cell have life cycles of their own, constantly being broken down and replaced by other cells. The average lifetime of a protein molecule in a mammal is around two weeks. So "why this ceaseless flux?" asks Rose (1997, p. 158).

The answer is simple . . . living systems need to be dynamic if they are to survive, able to adjust themselves to the fluctuations which, even in the best-buffered internal milieu, their cooperative existence as part of the greater unity of the organism demands. Thus, Rose (1997, p. 159) argues, it is

> to this irreducible dynamism as the generator of stable order that we must now turn in order to understand how, having constructed itself through the processes of development, the organism is able to preserve its integrity and act upon the external world.

As Rose (1997, p. 161) notes, the reductionist approach to biology disassembles cells into the various molecules that comprise them and "follow each enzyme reaction through which they are transformed in terms of both its chemistry and its energetics". Chemistry has dealt with the energetics of such reactions within the framework of thermodynamics; a science "concerned with equilibria, the final balance points between energy-yielding and energy providing reactions, and the mathematics and physics of such equilibria [are] well understood" (Rose, 1997, p. 161).

"Simplistically, the net effect of all the energy-utilizing and energy generating reactions should be that the cell is in thermodynamic and catalytic balance, and should equate to the life-process itself" (Rose, 1997, p. 161-162). Indeed, during the 1920s and the 1930s scientists devised various complex experiments on living organisms kept in closed metabolic chambers to prove that this was indeed the case (Rose, 1997).

As Rose (1997, p. 162) points out, however, if we are to truly understand the complexity of the processes which occur within living systems "we have to take them out of their closed metabolic cages". Living systems, argues Rose (1997, p. 162) are not sealed off from the world, "they are open . . . and in constant interchange with their environment . . . Life is not characterized by the static balance of completed reactions but by dynamic equilibrium". In the case of humans, of course, a crucially important aspect of 'the environment' is other humans, the social world, within which we are enmeshed and upon which we depend, and the meanings we assign to the actions of ourselves and others within that world.

Rose (1997) suggests that the thousands of chemical reactions taking place at any moment within a cell constitute a complex interacting web. The reductionist, having studied each of these reactions individually, would then attempt to build them up into sequential chains, "recognizing that the products of one enzyme-catalysed reaction will immediately serve as the substrates for another" (Rose, 1997, p. 162). Such an approach is, argues Rose (1997), far too simplistic. One cannot abstract from the "metabolic dance of the molecules" any single reaction pathway. The various substances involved in this 'dance' participate not just in one "but in many interacting pathways, and the factors which may influence the rate of any individual enzyme reaction then multiply dramatically" (Rose, 1997, p. 164).

Once this metabolic web becomes sufficiently complex it becomes strong, stable and able to resist change. But the stability does not reside in the individual components; rather it resides within the whole of the web itself. As Rose (1997, p. 166) goes on to note

> the metabolic web has a further advantage over one made of mere fabric. Unlike living systems, human artefacts such as fabric cannot compensate for the loss of any individual thread. The cellular web, however, has a degree of flexibility which permits it to reorganize itself in response to injury or damage.

These properties of stability and self-organization are, argues Rose (1997, p. 166) "the key to appreciating the fundamental irreducibility of living cells". The metabolic organization of each cell is not just the sum of their parts, and one cannot predict this metabolic organization simply by "summing every enzyme reaction and

substrate concentration that we can measure. For us to understand them we have to be able to understand the functioning of the entire ensemble" (Rose, 1997, p. 166). Stability and self-organization also explain why the equilibrium achieved by the cell is a dynamic rather than a static one, notes Rose (1997). "The essence of the stability of the whole is that the individual components are in constant flux" (Rose, 1997, p. 166).

But homeodynamic order within the cell is not maintained just through the self-stabilizing properties of metabolic webs, it is also maintained "through internal structural constraints set by semipermeable lipid membranes in which are embedded proteins that recognize and regulate the entry and exit of key metabolites" (pp 168-169). As Rose (1997, p. 169) notes, "[t]he internal components of the cell are in constant motion . . . the traffic and interaction of dynamic order".

Further, as Rose (1997) points out, these internal structures are created via a complex series of interactions between genes and the environment. Without the genes the amino acid chains that constitute the proteins could not be synthesised. How these chains fold is, however, affected by the microenvironment of the cell. The folding patterns and the shapes which result are not predictable from the DNA sequences, they depend on the environment as well. Thus Rose (1997) argues

> [l]ifelines . . . are not embedded in genes; their existence implies homeodynamics. Their four dimensions are autopoietically constructed through the interplay of physical forces, the intrinsic chemistry of lipids and proteins, the self-organizing and stabilizing properties of complex metabolic webs, and the specificity of genes which permit the plasticity of ontogeny. The organism is both the weaver and the pattern it weaves, the choreographer and the dance that is danced.

4.2.4. Summary and Implications

Within the dynamic systems[5] view of biological development taken by Rose (1997), the lifeline of an organism is constructed via its enmeshment in its environment, and cannot be understood without taking that environment into account – an insight which mirrors the social constructionist position that a person cannot be understood separately from the social world within which s/he is enmeshed.

As Rose (1997) further notes living systems "are in constant interchange with their environment [and thus] life is not characterized by the static balance of completed

[5] The dynamic systems approach will be discussed in more detail in Chapter Five (Section 5.2.1).

reactions but by dynamic equilibrium" (Rose, 1997, p. 162). As noted above, in the case of humans a crucially important aspect of 'the environment' is other humans, the social world, within which we are enmeshed and upon which we depend, and the meanings we assign to the actions of ourselves and others within that world.

The social constructionist analysis presented in Chapter Three makes the same point about our personal being. As Shotter (1993b, p. 7) points out, while our personal being, central to which is our sense of 'self', emerges from the "contingent flow of continuous communicative interaction between human beings" it is never, at some point, entirely complete. Rather, at all times in a person's life their personal being is partially 'constructed' and, also, open to further construction, re-construction or even 'de-construction'.

Again reflecting the social constructionist account presented in Chapter Three, Rose (1997, p. 153) also stresses that "the present instant of ours or any organism's life, is simply inexplicable biologically if considered merely as a frozen moment of time" and that "each of our presents is shaped by and can only be understood by our pasts, our personal, unique, developmental history as an organism". If neither our biological being nor our personal being can be understood outside the context of the lifeline of the organism/person then neither can our psychological suffering.

Hence, this account will be a 'developmental[6]' one, though, in line with Rose's (1997) analysis, development will be conceptualised as a "constructivist process" whereby the organism, via its enmeshment with its environment, essentially "constructs its own future" (p 153), rather than naturally unfolding according to a pre-determined 'blueprint'. Such a view, as Rose (1997, p. 153) notes, emphasises "the role of chance and of contingency, at all levels of analysis of living systems" (Rose, 1997, p. 153) and the radical indeterminacy of all our life trajectories.

In line with Rose's analysis, developmental psychologist Gilbert Gottlieb (1991) suggests that the outcomes of development (behavioural, organic or neural) are a consequence of at least two, and in many cases more, specific components of the system interacting (or, to use Gottlieb's term, 'coacting'). Some examples of such 'coactions' include, person-person, organism-organism, organism-environment, cell-cell, nucleus-cytoplasm, sensory stimulation -sensory system, and activity-motor behaviour.

As Gottlieb (1991) further notes, it is the relationship of the two components, not the components themselves, which drives development. Thus, "genes in themselves

[6] See Chapter Six for further discussion on 'developmentalism'.

cannot cause development any more than stimulation in itself can cause development" (Gottlieb, 1991, pp 7-8). Gottlieb (1991) suggests such coactions need to be at the heart of developmental analysis. As Gottlieb (1991, p. 8) points out, "the concept used most frequently to designate coactions at the organismic level of functioning is *experience*. Experience is thus a relational term". Thus, human beings (like all other organisms) are, as Eisenberg (1998) puts it, jointly moulded by nature and nurture.

In the next section I will discuss research concerning the foundational role of early social experiences, specifically those between an infant and their first caregiver, for the future socio-emotional functioning of that infant. Such research illustrates the central insight of Rose's approach to biology, that organisms cannot be understood separately from their environment and that their experiences in those environments are fundamental to the trajectory of their lifelines.

4.3. THE FOUNDATIONAL NATURE OF THE MOTHER-CHILD RELATIONSHIP

4.3.1. Introduction

There is now a considerable body of evidence to suggest that the basic functional building blocks for much of the mammalian infant's social development are formed early in life, mainly through the interaction of the infant and the mother (Schore, 2001b, 2001c). Indeed, as Hofer (2001, p. 822) points out "interactions with a caretaker appear to play the same role for an infant's affective and communicative development as early visual input [does] for its ability to see". As the opening of the Romanian orphanages has made clear, the basic physical requirements of infants may be met but if they are not involved in a 'love relationship' with another human being who is committed to their care and well-being then their ability to feel and express emotions and to communicate with others will not develop (Gunnar, 2001; Perry, 1997; Small, 1998; Taylor, 2002).

As Hofer (2001, p. 823) notes, "the general term used for the processes by which the infant's first social relationship is formed, regulated and expressed is 'attachment[7]"

[7] For Hofer (2005, p. 291) the term 'attachment' "remains useful as a concept, like hunger, that describes the operation of subprocesses that work together within the frame of a vital biological function". It should be noted that I will, at various points, draw on research findings from the 'attachment' literature which provide general support for the analysis being developed in this thesis. This does not imply a wholesale acceptance

or, colloquially, 'bonding'". As summarised by Hofer (2001, p. 823), attachment theory, developed by John Bowlby (1969, cited in Hofer, 2001, p. 823), suggests that

> the early responses of newborns consist primarily of species-typical reflex acts. These are thought to become slowly organized into a behavioural system that maintains proximity to the mother. Through repeated use and maturation, Bowlby theorized, this simple system gradually develops into a full-fledged attachment system (at about 7 to 8 months in the human) as it becomes imbued with affect and organized around an 'internal working model' (mental representation), specified by the infant's particular experiences with its mother up to that point in time. The mother goes through a similar process, strongly influenced by (unconscious) traces of her own experiences with her mother. The affective 'bond' thus formed is expressed in the infant's early positive emotional states of joy, comfort, security in the presence of the mother and the negative states of protest, anxiety, anger and despair elicited by separation from her.

As Hofer (2001) notes, however, there are unresolved questions inherent in this formulation. First, there is no clear articulation of how attachment is actually initiated. "Bowlby's (1969) primary definition of attachment is the infant's ability to seek proximity to a specific caregiver" but he never specified how an 'attached' state develops from an 'preattached' state (Pipp & Harmon, 1987, p. 648). Second, the theory has difficulty in

> explaining the slower-developing physiological and behavioural effects of early maternal separation and falls prey to circular reasoning in that the best evidence for the existence of attachment is the immediate (protest) response to separation, and yet attachment is then used as an explanation for the very protest response from which it was inferred.
>
> (Hofer, 2001, p 823)

Hofer (2001) notes that mounting neuroscience evidence for activity-dependent developmental brain processes has set the stage for a new view of attachment as deriving from specifiable regulatory processes recently found to be embedded in the interactions between infant and mother (Hofer, 1995, cited in Hofer, 2001). In this Section I will discuss research which has attempted to elucidate the developmental processes underlying the 'attachment' process, focusing on the work of Myron Hofer and his colleagues (Hofer, 1987, 2001, 2005, 2006; Hofer & Sullivan, 2001; Polan & Hofer, 1998, 1999a, 1999b) whose findings, as Pipp and Harmon (1987) have pointed out, have altered "the traditional perspective on human attachment in important ways".

Because experimental manipulations of the mother-infant interaction in humans are not possible, and because long-term observational studies from infancy to adulthood

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of the concept of 'attachment' as articulated by Bowlby (1969, cited in Hofer, 2001). While some aspects of attachment theory sit relatively comfortably with the analysis being developed herein, others do not, such as, for example, the mentalistic notion of the infant developing an 'internal working model' of its relationship with its mother.

are very difficult and take so long, the research discussed in this section has been carried out with rapidly developing laboratory species such as the rat. While one must be careful about generalizing across species such studies nevertheless provide us with some insight into the socio-biological processes that may be involved in the relationship between human caregivers and their infants.

4.3.2. Early post-natal learning

Although research has shown that predispositions towards the mother may be acquired prenatally (Hepper, 1987, Smotheram & Robinson, 1992, Robinson & Smotheram, 1995, cited in Hofer, 2001; Polan & Hofer, 1999a), after birth "the newborn enters a new world where contingent events, so important for more advanced forms of learning, are now occurring with greater frequency" (Hofer, 2001, p. 827). As Hofer (2001) points out, when developmental psychobiologists first began studying the development of rat pups they were not expecting to find the capacity for any kind of learning in the neonatal rat. Since then, however, a considerable amount of research has shown "that the basic laws of adult learning also apply to infant rats and that learning occurs naturally within the nest" (see Hofer, 2001, 918).

Indeed, Hofer (2001; 2001) reports a number of studies indicating that the kind of rapid learning process occurring in young rats resembles imprinting in birds. For example Sullivan et al. (cited in Hofer, 2001) found that associating a new smell with simulated licking of the pup resulted, after only a few repetitions, in the pup being able to select, approach and remain close to that odour. Interestingly it was not just pleasant forms of stimulation that resulted in this kind of learning. Even tail pinches and mild electric shocks paired with an odour during the first week of life, resulted in preferences for that odour.

As Hofer (2001, 917) points out, however, such aversive tactile stimulation, if delivered after the first week of life, stopped inducing preferences, suggesting "a sensitive period for the formation of positive associations reinforced by intense tactile stimulation" (Hofer, 2001, 917, p. 827). Hofer (2001, p. 827) suggests that this finding may help explain "the clinical observation that strong attachments can occur in children of abusive parents". As Hofer (2001, p. 827) points out

> [c]ues learned in this way can be highly specific to an identifying maternal feature, they acquire the capacity to elicit states of increased arousal and operate, at a distance, as

incentive cues in a motivational system that ensures close proximity of the infant to the mother.

As Hofer (2001, 918, p. 603) notes, research has shown that "a surprisingly broad spectrum of stimuli can function as reinforcers to produce an odor preference in rat pups" while they are in the nest, but that it "becomes more selective at a time in development when pups begin leaving the nest and encountering novel odors not associated with the mother".

4.3.3. The mother's regulation of infant systems

As the research discussed above makes clear, attachment begins soon after birth. Prenatally acquired perceptual biases, and motor programmes, and some very basic associative learning smooth the transition between the womb and the outside world, helping the infant to orient towards the mother and locate the source of milk. Once outside the womb stimulus-guided tactile responses and associative learning take over creating "a powerful behavioural control system through which the infant maintains close proximity to its mother" (Hofer & Sullivan, 2001, p. 607).

There is, however, another important attribute of attachment, the attribute from which the emotional tie of the infant to its mother has been inferred: the response to separation. As Hofer (2001, p. 607) points out, "this has been supposed to be an integral part of the proximity-maintenance system, one that represents the affective expression of its motivational nature". It has long been thought that the strength of an attachment is responsible for the intensity of the response to separation and "the separation response itself is taken to represent a full expression of attachment behaviours in the absence of their 'goal object'" (Hofer & Sullivan, 2001, p. 607).

The responses of infant rats, and of primates, to separation from the mother "involve a complex pattern of changes in a number of different behavioural and physiologic systems" (Hofer & Sullivan, 2001, p. 607). Hofer (1987) provides a summary of infant responses to separation from their mother across several animal species, including human beings, and notes "the broad outline and even some of the details are surprisingly similar for different species" (Hofer, 1987, p. 638). During the first, or 'protest' phase of separation there is an increase in agitation, vocalisation and searching activities. There is also an increase in heart rate, and in cortisol and catecholamine levels.

If the separation lasts for a longer period of time this response "merges into the slow-developing changes of the so-called despair phase" (Hofer, 1987, p. 638). Some of the behavioural signs of this phase are decreased social interaction and play, mouthing and rocking, hypo- or hyper-responsiveness, decreased or variable food intake and postures or facial expressions indicative of sadness. Physiological signs include a decrease in weight, sleep disturbances, a decrease in core temperature, oxygen consumption, heart rate, and growth hormone levels (Hofer, 1987).

As Hofer points out, it has been assumed that the protest and despair phases were both part of the same process, with Bowlby (1969, cited in Hofer, 1987) proposing that both phases are 'strategies' selected by evolution because of their adaptive value. The arousal of the protest stage was thought to be useful in helping the mother to locate the lost infant and the inhibition of the despair phase was thought to help the infant hide safely from predators and conserve its energy until the return of its mother.

Experiments carried out by Hofer and his team (see Hofer, 1987 for a summary of these), however, caused them to question this 'tidy view' (Hofer, 1987). Hofer and his colleagues found, to their surprise, that the "slow-developing changes in the rat continued to occur, even when the acute protest phase was completely prevented by the presence of effective surrogates" (Hofer, 1987, p. 638). As Hofer (1987, pp 638-39) notes, "we were forced to conclude that the slow-developing changes were independent of the acute isolation distress and that the two phases might be caused by different processes".

In a series of experiments Hofer and his team (reported in Hofer, 1987) found that a single aspect of the mother-infant relationship could prevent one of the physiologic changes characteristic of the 'despair' phase without affecting any of the others. Hofer and his team found that when separated from their mother "each of the individual systems of the infant rat responded to the absence of one or another of the components of the infant's previous interaction with its mother" (Hofer & Sullivan, 2001, p. 607). Thus, if one of these components was provided to a separated pup, for example maternal warmth, this would maintain the level of brain biogenic amine function underlying the pups' general activity level but it had no effect on other systems, for example the pups' heart rate. Heart rate, however, was found to be regulated by "maternal provision of milk to neural receptors in the lining of the pup's stomach" (Hofer & Sullivan, 2001, p. 607).

Other systems, such as those controlling sleep-wake states, activity level, sucking pattern, vocalization and blood pressure were also found to be regulated by

specific components of the infant's interaction with its mother (see Hofer & Sullivan, 2001, p. 607). This led Hofer (1987, p. 639) to conclude that

> [t]he pattern of slow-developing changes was in reality a composite or assemblage of separate independent processes, each operating over a different pathway. The only reason that all of these changes occurred as a pattern in the separated infant was because all of the individual processes were activated at once by the withdrawal of all active aspects of the mother-infant relationship simultaneously.

This loss will either decrease or increase levels of function across the infant's various biological systems, depending on whether that system had been up- or down-regulated by the mother-infant interaction. Hofer (1987; 2001) calls these regulatory functions performed by the interactions between mother and infant 'hidden regulators' because they are not evident by just observing the interaction between the mother and the infant.

Hofer (1987, p. 639) points out that "each of these regulators within the normal mother-infant interaction has its own dynamics and its own transduction mechanisms". Some interactions with the mother, for example, act to maintain relatively high levels of function within their system under normal conditions (e.g., heart rate and oxygen consumption). Other interactions act to down-regulate their systems (e.g., those underlying behavioural reactivity, arousals during sleep and sucking) under normal conditions.

These studies suggest "that the infant's homeostatic system appears to be relatively 'open'" and that regulation of the infant's biological functions is delegated, at least in part, to the mother (Hofer, 1987, p. 639). Such research reveals "how differences created in the nature and quality of behavioural interaction within the dyad can have marked effects on the infant's response after separation and suggest the presence of regulators within the interaction that determine the form of the response after withdrawal by separation" (Hofer, 1987, p. 641).

As Hofer (2001) points out, other investigators have discovered additional maternal regulatory systems that further support his thesis. For example, a study by Schanberg and Field (1987, p. 1442) found that when 10-day-old rat pups are separated from their mothers for only 1-hour ornithine decarboxylase[8] (ODC) was "markedly diminished in the vital organs of rat pups". Further, the author's noted that this decrease was

[8] An enzyme that is involved in protein synthesis and "a sensitive index of tissue growth and differentiation" (Schanberg & Field, 1987, p. 1442).

> triggered specifically by the loss of tactile stimulation from the mother, as opposed to the absence of sensory cues from littermates, passive stimuli from the mother, or nutritional deprivation.

Separating rat pups from their mother also resulted in a decrease in growth hormone (GH) secretion and also a "loss of tissue sensitivity to exogenous growth hormone" (Schanberg & Field, 1987, p. 1442). Furthermore, Schanberg & Field (1987, p. 1442) found that "only a specific type and pattern of tactile stimulation (brush strokes mimicking their mother's licking pattern) reinstated normal functioning of these processes".

As Wexler (2006, p. 90) points out, a number of "persistent abnormalities in multiple neurotransmitter systems" are also found in animals separated from their mothers during infancy. Some examples of altered neurotransmitter systems in infant rats who have been separated from their mothers for varying periods of time include: expression of the dopamine transporter gene and dopamine-mediated stress responses (Meaney, Brake & Gratton, 2002, cited in Wexler, 2006), expression of serotonin receptor mRNA (Siburg, Oitzl, Workel, de Kloet, 2001, cited in Wexler, 2006), expression of benzodiazepine receptors (Caldji, Francis, Shasrma et al., 2000, cited in Wexler, 2006), sensitivity of glucocortocoid receptors related to stress response (Francis, Diorio, Plotsky et al., 2002, cited in Wexler, 2006), and sensitivity to morphine (Kalinachev, Easterling & Holtzman, 2002, cited in Wexler, 2006).

In addition to altering the functioning of the brain, early separations from the mother also seem to result in alterations to the structure of the brain (Wexler, 2006). Rat pups separated from their mothers for 24 hours showed a twofold increase in the death rate of neurons and glial cells in the cerebral and cerebellar cortices, and in the white matter tracts that link different brain regions (Zahn, Levine, Dent et al., 2002, cited in Wexler). Monkeys who were repeatedly separated from their mothers for 5-hour periods between the ages of 13 and 21 weeks had abnormally large right frontal brain regions as adults. Although the time at which this subsequent abnormality developed is unclear, it is thought to probably result from an abnormal decrease in the cell pruning that usually takes place around the time of sexual maturation (Lyons, Afariana, Schatzberg et al., 2002, cited in Wexler).

4.3.4. Long-term effects of mother-infant interactions

As Hofer (2001, p. 830) points out, the maternal regulators inherent in the interaction between mother and infant exert their effects on the biology and behaviour of infants "throughout the preweaning period and even beyond". Hofer (2001) notes that this is illustrated by the discovery of a major role for the mother-infant interaction in the development of the hypothalamic-pituitary-adrenal axis (HPA) – a major part of the neuroendocrine system that controls reactions to stress and is thought to regulate many processes, including digestion, the immune system[9], mood and emotions, and sexuality.

In mid-infancy (postnatal days 4 o 14) the HPA response of the rat pups to isolation and to mild stressors is less intense than in the newborn or weaning periods – a species-typical developmental stage known as the 'stress-hyporesponsive period'. It was recently found, however, that rather than being the product of an intrinsic developmental programme as initially thought, it was actually the result of hidden regulators within the ongoing mother-infant interaction (see Hofer, 2001).

By analysing the activity of rat pups' neuromodulators in response to various experimental manipulations while separated from their mothers a group of researchers (Stanton, Gutierrez, & Levine, 1988; Suchecki, Rosenfeld, & Levine, 1993; van Oers et al., 1998, cited in Hofer, 2001) have "discovered that maternal licking and milk delivery during suckling exerted an unexpected and prolonged attenuating effect on the responsiveness of the HPA" (Hofer, 2001, p. 831). This regulatory effect continues throughout most of the time the pups are nursing and finally declines as weaning occurs. As Hofer (2001, p. 831) points out,

> [t]hese regulatory interactions achieve this effect by increasing the inhibitory feedback from hippocampal glucocorticoid receptors and by decreasing the hypothalamic stimulation of CRF and ACTH output. These regulatory effects on the pup's brain can be rapidly reversed by maternal separation.

A study by Liu, Diorio, Tannenbaum, Caldji, Francis, Freedman et al. (1997) suggests that the effects on the infant of the quality of interactions it has with its mother can be even longer lasting. Liu et al. (1997) were interested in finding out why different maternal behaviour of rat dams towards their pups resulted in differing HPA responses to stress in their offspring. It has long been known that separating pups from their mothers for three to fifteen minutes every day leads to decreases in fearfulness, stress

[9] Research suggests that early separations from the mother may result in a compromised immune system, with experimentally induced autoimmune encephalitis being more severe in adult rats who have been separated from their mothers in infancy, (Stephan, Straub, Brivik et al., 2002, cited in Wexler, 2006).

reactivity, steroid release from the adrenal glands during stress, and hippocampal aging as adults (Wexler, 2006). As Liu et al. (1997) point out; these effects were found to be due not to separation from the mother *per se*, but to handling of the pups during separation by human beings. Liu et al. (1997, p. 1659) further note that a number of authors have proposed that "handling the pups altered the behavior of the mother and that these differences in mother-pup interactions then mediate the effect of handling on the development of endocrine and behavioral responses to stress".

Liu et al. (1997) examined the behaviour of mothers of handled or non-handled litters over the first ten days (known to be a critical period for the 'handling effect' on HPA development) of their life. Mothers of pups who were handled showed increased levels of licking and grooming of pups and arched-back nursing (LG-ABN) compared with mothers of non-handled pups. To determine whether the increased maternal licking and grooming affects the development of the HPA responses to stress, Liu et al. (1997, p. 1659) then examined the relation between naturally occurring individual differences in maternal care and HPA development.

To do this, the researchers selected a group of dams that showed higher licking and grooming behaviours (also highly correlated with high arch-backed nursing) and then assessed the HPA responsivity of their offspring. They found that, as adults, the offspring of the high LG-ABN mothers "showed significantly reduced plasma ACTH and corticosterone responses to restraint stress compared with the offspring of low-LG-ABN mothers", but that there were no differences in basal hormone levels (Liu et al., 1997, p. 1660). The authors noted that these findings parallel those observed in handled versus non-handled rats, which also differ in stress-induced, but not in basal HPA activity.

Liu et al. (1997) also found "increased hippocampal glucocorticoid receptor messenger RNA expression, enhanced glucocorticoid feedback sensitivity, and decreased levels of hypothalamic corticotropin-releasing hormone messenger RNA expression" in the adult offspring of high-LG-ABN mothers. These findings also parallel those observed in handled versus non-handled rats. Liu et al. (1997) note that these findings suggest that "maternal behavior serves to 'program' hypothalamic-pituitary-adrenal responses to stress in the offspring" (Liu et al., 1997, p. 1659).

In line with these findings, research by Maestripieri and his colleagues (Maestripieri, Higley et al., 2006; Maestripieri, McCormack, Lindell, Higley, & Sanchez, 2006) showed that rhesus monkey infants who were exposed to higher levels of maternal

rejection in their first 6 months of life exhibited significantly lower CSF concentrations of serotonin and dopamine metabolites in their 1st, 2nd and 3rd years of life than did infants exposed to lower levels of maternal rejection.

Wexler (2006) also points to a number of studies with monkeys which demonstrate the effects of compromised mother-infant relationships on more complex aspects of adult social behaviour, some of which my have direct parallels in human beings. As Wexler (2006) notes, studies comparing infants separated from their mothers at birth and raised in small peer groups and infants raised by their mothers "are most informative since both groups have ample social and physical contact with members of their own species" (Wexler, 2006, p. 93).

A review by Kraemer (1997) outlines how peer-reared and mother-reared monkeys show many behavioural differences as infants and juveniles and as adults. Peer-reared monkeys are consistently rated as being more timid, fearful and emotionally labile than mother-reared monkeys and as infants and juveniles they spend more time sucking their fingers and toes, and clinging to their peers. The interactions amongst these monkeys seem chaotic "with individuals being either inordinately separated from group activity or intensely engaged, with rapid fluctuations between the two" (Kraemer, 1997, p. 407).

Peer-reared monkeys are consistently rated as being "in a chronically higher 'tension' or 'stress' state than groups of mother-reared monkeys" (Kraemer, 1997, p. 407) and they are also more likely to "have a severe response to separation from there [sic] cagemates than are mother-reared monkeys living in peer groups as juveniles" (Kraemer, 1997, p. 407). Aggressive behaviour is less common in peer-reared monkeys, but when it does occur it is more likely to lead to injury. Peer-reared juveniles show more signs of stress when separated from their cage-mates and trained observers rate them as more tense, timid and emotionally labile.

Peer-reared monkeys also show different baseline and stress-related levels of brain neurotransmitters and circulating hormones with the peer-reared monkeys showing blunted responses in some and exaggerated responses in others. As Wexler (2006, p. 94) notes "these observations indicate deficient biobehavioral self-regulation in the peer-reared monkeys". Monkeys reared in total or partial isolation show additional deficiencies in self-regulation including altered temperature regulation, abnormal eating patterns and impaired regulation of body weight (29, cited in Wexler, 2006). These findings are not surprising in the light of Hofer's (1987, 2001) finding that the mother

plays a key role in regulating the infant's biological functions. As Kraemer (1997, p. 404) notes, "being mothered . . . is the most important thing for the psychobiological development of the infant".

Kraemer (1997) notes that there seems to be evidence of decreased neurobiological structure or organization in peer-reared monkeys. Mother-reared monkeys show significant correlations among the activity of different brain neurotransmitter systems, among different measures of behaviour, and between neurotransmitter and behavioural measures. Most of these correlations are significantly reduced or absent in peer-reared monkeys. Kraemer (1997, p. 411) notes that this finding suggests,

> first that the correlations among measures that are observed in socially reared monkeys are not attributable to necessarily interlocked neurochemical or transport mechanisms, and second, that important aspects of neurobiological organization are attributable to mother-infant attachment and do not occur if the monkey has no mother.

There have been a number of studies which have attempted to make more ecologically natural interventions in mother-infant interactions by requiring the mothers to spend more, or less, time foraging for food (Variable Foraging Demand paradigm). Coplan, Pauncia, & Rosenblum (2004), in a review of this literature, noted that such studies suggested that

> [t]he psychosocial stress induced by the VFD (variable foraging demand) paradigm has a clear impact on the ability of primate mothers to provide consistent and adequate parenting towards their infants . . . [and] the extensive data on the neuropsychobiology of the offspring demonstrates the powerful influence unpredictable rearing wields over the future development of the primate CNS.

As Wexler (2006, p. 96) points out, "it is problematic for environmentally dependent organisms when the environment (in this case maternal presence and behaviours) changes so that it no longer matches the expectations and internal neuropsychological structures generated by the previous environmental conditions". This is perhaps particularly so for human beings who are not only highly environmentally dependent in terms of our development, but who are also living in a world which is changing extremely rapidly and which, with each generation, is becoming less and less similar to the environment within which we, as organisms, evolved (Keverne, 2004).

4.4. THE HUMAN MOTHER-CHILD RELATIONSHIP AS A REGULATOR OF INFANT SYSTEMS

The research outlined above describes a number of behavioural systems that act together to encourage the infant to seek, and maintain, close proximity to the mother and which cause "a complex patterned response to prolonged maternal separation" (Polan & Hofer, 1999, p. 177). As Polan and Hofer (1999b, p. 177) note, these systems

> indicate that an 'enduring social bond' (to use Bowlby's term) has been formed, but we can now understand the bond in terms of separate processes that can be delineated as they work independently, serially, or in parallel to produce the familiar behavioural signs of 'attachment'.

This research has shown how the early relationship between a mother and her infant shapes the developing physiology and the behaviour of the infant and, as Polan and Hofer (1999, p. 177) point out, how "behavioral adaptations to environmental change occurring in the life of the mother can thus lead to biological changes in the offspring – a novel evolutionary mechanism".

As Polan and Hofer (1999, p. 177) further note, their research findings have moved them "conceptually . . . from using a hierarchical goal-corrected control system as [their] model, to using a self-organizing regulatory system composed of mother and infant as a unit". The role of 'attachment behaviour' can thus be seen in a new light: "It provides the 'glue' that holds mother and infant together and allows the whole mutual regulatory system to be formed and maintained" (Polan & Hofer, 1999b, p. 178).

While one must be cautious about generalizing between species, as has been noted above, because the essential phenomena associated with infant attachment – seeking proximity to the mother and the distress response to separation from the mother – occur in most mammals, "the basic underlying mechanisms (from genes to neurobehavioural systems) are likely to be similar in all mammals" (Polan & Hofer, 1999b). Thus, the research discussed above provides us with insights into the socio-biological processes that may be involved in the relationship between human caregivers and their infants.

Indeed, the plasticity of human brain structures and functions (Huttenlocher, 2002), and the fact that infancy and childhood lasts much longer in humans than in other mammals (Blaffer Hrdy, 1999; Small, 1998), suggests that the physiological regulatory

effects of our early social interactions will have a commensurately greater effect on our development than it does for other animals. As McKenna and McDade (2005, p. 138) point out, the human being is born with only 25 percent of its brain volume and is thus "neurologically the most immature infant primate of all, the slowest developing and the most reliant on its mother for the longest period of time for physiological regulation and support". Indeed, these authors suggest that "nothing that a human infant can or cannot do makes sense except in the light of the mother's body" (McKenna & McDade, 2005, p. 138).

While there is comparatively little biologically oriented research concerning humans what there is suggests that the interactions between human mothers and their infants fulfil the same functions, and have the same fundamental importance, as those between mothers and infants in other species. Human babies, in common with newborn rats (Polan & Hofer, 1999b), for example, arrive in the world equipped with a number of orienting and approach behaviours that, as Polan and Hofer (1999b, p. 169) point out, "serve as building blocks from which a filial attachment system can be constructed".

As Hofer (2001) notes, recent research with humans has shown that newborns are capable of slowly moving across the bare surface of their mother's stomach and locating a breast scented with amniotic fluid in preference to one which was unscented (Verendi et al., cited in Hofer, 2001). This suggests that human newborns are not as helpless as previously thought and "possess approach and orienting behaviours that anticipate the recognized onset of maternal attachment at 6 to 8 months" (Hofer, 2001, p. 826)

As Wexler (2006, p. 97) points out, the dependence of the developing infant on social-sensory stimulation from the outside world, and the intensity of pre- and postnatal social-sensory experience means that the human mother and her infant are rapidly linked in

> mutually regulating dyadic systems. The resulting synchronization and mutual contingency of infant-adult behaviors are evident in sleep and electroencephalogram patterns . . . direction of gaze . . . facial expressions . . . vocalization . . . and cardiac and behavioral rhythms.

As Wexler (2006) goes on to note, the behaviour of the adults who are linked with the infants in this way thus exerts a profound effect on the infant's general physiological state and its orientation to sensory input. If an agitated baby is rocked or walked around with this helps soothe them and ease their transition into sleep (e.g., Ter Vrugt & Pederson, 1973, cited in Wexler, 2006). Slow, deep vocalization also soothes

agitated babies, while an increased pitch and timbre can rouse a baby from light sleep to alert awareness. An increased tempo and a staccato rhythm (such as would be experienced if an adult was angry or excited) can over-arouse an infant so much they start crying (Brazelton, 1982, cited in Wexler, 2006). Infants have even been shown to move in synchrony with the adults who are interacting with them (Condon & Sander, 1974, cited in Wexler, 2006).

Small (1998) cites a study by Yogman, Lester & Hoffman (1983, cited in Small, 1998) which illustrates how biologically entrained babies are with adults with whom they have a close physical and emotional relationship. In this study a baby girl was brought into a laboratory and placed in a seat that was curtained off from all other distractions. The baby was then approached by her mother, then her father, and then a stranger. Chest monitors attached to the baby and to the adult participants in the study showed that "the baby synchronized her heart rate to that of the mother or father when they approached, but she did not synchronize her heart rate to the strangers".

McKenna and McDade (2005) note that responses to separation from the mother in humans are consistent across and within cultures. For example, newborns can lose up to one degree of temperature when removed from their mothers' ventrums following birth, even when they are placed in incubators where the ambient temperature matches that of the mother's body (Fardig, 1980, cited in McKenna and McDade, 2005). Research has also shown that 11-16 week old infants who are sleeping alone have lower axillary skin temperatures compared with infants who are sharing a bed with their mothers (Tuffnell, Peterson & Wailoo, cited in McKenna and McDade, 2005).

As McKenna, Thoman, Anders, Sadeh, Schectman & Glotzbach (1993) point out infant thermoregulation, in common with other immature central nervous system (CNS) homeostatic subsystems, may not be as efficient when the infant is alone as it is in the evolutionarily 'expectable' social environment of being physically close to the mother.

Furthermore, a study by Feldman, Weller, Sirota and Eidelman (2002) suggests that skin-to-skin contact or 'kangaroo care' increases the ability of premature infants to regulate their physiological processes (e.g., sleep patterns, temperature and oxygen consumption). Research into infant sleep has also suggested that having a parent in close proximity ('co-sleeping') may help the infant's immature nervous system learn to self-regulate during sleep (for a review see McKenna et al., 1993).

McKenna's research (McKenna, Mosko, Richard et al., 1994; Mosko, Richard & McKenna, 1997, cited in McKenna & McDade, 2005) suggests that co-sleeping may help

protect against SIDs by preventing the infant from entering sleep states that are too deep for it to arouse itself from and that the sound and the feel of parents breathing may help the infant to 'remember' to breathe. McKenna et al. (1993) also point out that research has shown that 'rooming-in' newborns spend more time in quiet sleep than those infants who were away from their mothers in the hospital nursery.

Maternal behaviour also exerts an influence on the regulatory processes of the sympathetic nervous system, which is involved in affect regulation. As Calkins and Hill (2007, p. 240) note, "during homeostasis the PNS enhances restorative and growth processes" but during a challenging or 'stressful' situation the PNS influences the regulation of cardiac output via the vagal nerve pathways. Calkins and Hill (2007, p. 240) cite research that suggests that caregiver behaviour may affect this physiological system. For example, a number of studies have shown that

> mother-infant coregulated communication patterns and more responsive parenting are positively related to good vagal regulation, and maternal intrusiveness and restrictive parenting are negatively related to such regulation.

The above-mentioned research suggests that the mother-infant interaction performs the same regulatory function for humans as it does with rats, with behaviours such as cuddling (tactile stimulation/body warmth), rocking and walking, various sorts of vocalisations, provision of milk, etc., acting as maternal regulators of immature human biological and neurobiological systems. This research also suggests some of the infant systems which may be regulated in this way – control of sleep-wake states and self-regulation during sleep, thermoregulation, vagal regulation and possibly even regulation of breathing.

Research by Schanberg and Field (1987) suggests that the mother-infant interaction may also regulate the levels of growth hormone secretion in the human infant. As already noted above, a study by Schanberg and Field (1987)) established that separating rat pups from their mother resulted in a decrease in growth hormone (GH) secretion and a "loss of tissue sensitivity to exogenous growth hormone" (Schanberg & Field, 1987, p. 1442). As also noted above, Schanberg and Field (1987) also found that only a specific kind of tactile stimulation (brush strokes which mimicked their mother's licking pattern) reinstated normal functioning of growth hormone secretion and tissue sensitivity to exogenous growth hormone in the infant rat.

Schanberg and Field (1987) went on to explore the possible application of their animal model to preterm human newborns and found that a combination of stroking

and limb movement, given for 15 minutes three times a day throughout a two-week period of hospitalization resulted in gains in weight and head circumference and in better behaviour development test scores than a randomly chosen control group. These beneficial effects were still discernible many months later. These results suggest that somato-sensory stimulation from the mother may act as a 'maternal regulator' of the human infant's secretion of growth hormone.

Schanberg and Field (1987) make the link between their research and clinical findings of "impaired growth hormone secretion and tissue responsivity to growth hormone in nonorganic 'psychosocial dwarfism' children" (Schanberg & Field, 1987, p. 1442). As Schanberg and Field (1987) point out, even when these children are well fed they fail to secrete growth hormone normally and the only thing that helps such children to return to normal is being provided with adequate somato-sensory stimulation.

As Schore (2001b) notes, the experiences necessary for experience-dependent brain maturation are created within the context of the relationship between a child and his/her primary caregiver. If the mother-child relationship fails, for some reason, to adequately regulate the child's developing neurobiological systems and buffer the child against stress then the consequences for the child's ongoing neurodevelopment will be adverse (Tiecher et al., 2003, p. 33). Given the regulatory functions provided by the mother-child relationship, and the physiological stress which inevitably ensues if these functions are not adequately regulated, it is not surprising that research has found that a number of neurobiological systems seem to be 'dysregulated' by early relational problems.

As Tiecher, Andersen, Polcari, Anderson, Navalta and Kim (2003, p. 33) note, "early severe stress and maltreatment produces a cascade of neurobiological events that have the potential to cause enduring changes in brain development". These authors point out that such changes occur on multiple levels, from neurohumoral (especially the hypthothalamic-pituitary-adrenal (HPA) axis), to structural and functional.

For example, the results of a study by Wismer-Fries, Ziegler, Kurian, Jacoris and Pollak (2005) suggest "a failure to receive species-typical care disrupts the normal development of the OT (oxytocin) and AVP (arginine vasopressin) neurohypophyseal peptide systems in young children". These systems are "an integral part of mammalian emotional circuitry" (Wismer-Fries, 2005, p. 17,237) and are associated with the "emergence of social bonding, parental care, stress regulation, social communication,

and emotional reactivity" (Wismer-Fries, 2005, p. 17,237). OT and AVP levels increase during socially pleasant experiences, such as comforting touch and smells.

Wismer-Fries et al. (2005, p. 17,239) suggest that "perturbations in this system may interfere with the calming and comforting effects that typically emerge between young children and familiar adults who provide care and protection" and provides further illustration of the effect of social deprivation on the neurobiological mechanisms that subserve the regulation of emotional behaviour.

A number of authors also point out that there is evidence that chronic stress and persistent glucocorticoid elevation may be particularly toxic to the hippocampus. Mirescu, Peters and Gould (2004), for example, note that in rats maternal deprivation produces persistent abnormalities in behavioural and neuroendocrine functions associated with the hippocampus. These authors suggest that this indicates "that early adverse experience inhibits structural plasticity via hypersensitivity to glucocorticoids and diminishes the ability of the hippocampus to respond to stress in adulthood" (Mirescu et al., 2004, p. 841).

Clinical studies of people with a history of abuse, which implicate dysfunction of the hippocampal system, suggest that adverse experiences may have the same effect on this part of the brain for human beings (Bremner & Vermetten, 2001; Bremner et al., 2003). This conclusion is also supported by studies that have found "interrelationships among stress, cortisol function, hippocampal volume, and hippocampus-dependent cognition in stress-related disorders" (Corcoran et al., 2003).

Early ongoing relational problems, then, place the organism under chronic physiological stress. The effects of that stress then reverberate through the brain resulting in the eventual 'dysregulation' of a number of neural systems. As Schwarz & Perry (1994, p. 311) state, "the tenacious effects of trauma are rooted in the well-characterized total initial body freeze, fight or flight, alarm or stress response to life threat". This complex set of processes includes "activation of the centrally-controlled peripheral autonomic nervous system tone, the immune system, the hypothalamic-pituitary axis . . . and of other neurochemical systems in the central nervous system".

As Schwarz and Perry (1994, p. 312) further note, evidence is accumulating that the "cascade of cellular and molecular processes" which occur when an organism is under stress

> alter brain structure and function to create an adaptive record of survival-related information. Intense danger activates the neurosensory apparatus and alters the pattern

> and quantity of neurotransmitter release throughout neuronal systems responsible for sensation, perception and processing of survival information. Neurotransmitter receptor/effector activation then alters intracellular chemical constituents . . . Changes in these messengers alter the micro-environmental milieu of the nucleus.

Echoing Rose's (1997) point that genes do not play the lead role in development, rather they are 'designed' to work within an environment, these authors note that such micro-environmental alterations can result in changes in gene transcription and expression of proteins, "including sensitization of receptors to similar future neurotransmitter stimulation in all synaptically connected neurons" (Schwarz & Perry, 1994, p. 312). Thus, as Rose (1997) points out, genes are turned on and off by micro-environmental cues and these cues, in turn, are influenced by the experience of the individual.

The main neural systems involved in the human stress response are the norepinephrine-sympathetic adrenomedullary (NE-SAM) system and the hypothalamic-pituitary-adrenocortical (HPA) system[10]. The HPA axis regulates the slower acting responses to stress, while the NE-SAM system regulates acute stress responses (Yates, 2007). As Yates (2007) points out, the central nucleus of the amygdala activates both the L-HPA and the NE-SAM systems, via connections with the hypothalamus and brainstem, respectively, in response to anything perceived as threatening.

These two networks operate at various places throughout the central and the peripheral nervous systems and modulate the various aspects (behavioral, emotional, cognitive, metabolic, immunological, autonomic, and endocrine) of the mammalian stress response" (Yates, 2007). As De Bellis (2005, p. 155) points out, "arousal, stress response, behavioral, and emotional regulation are all dependent on these systems" and that, "importantly, neurodevelopment is also dependent on these systems".

In the following discussion I will focus in particular on the impact of inadequate and abusive care-giving on the HPA system, an aspect of human neurobiology which is particularly open to the effects of experience during development because of its extreme and lengthy post-natal plasticity (Perry, 2000; Pollak, 2005; Wismer Fries et al., 2005; Yates, 2007), the repercussions of problems in this system on other brain systems, and its centrality to the neurobiological and subjective aspects of psychological suffering (Walker & Diforio, 1997; Davidson, 2002). Further, as Gunnar and Cheatham (Gunnar & Cheatham, 2003) point out, the HPA axis has been widely studied in children because its

[10] Also known as the limbic-hypothalamic-pituitary-adrenocortical (L-HPA) axis.

end product, cortisone, can be measured simply through obtaining samples of saliva. The HPA axis is also, as Gold (2005, p. 319) points out "among the most frequently studied mediators in all of psychiatric research".

As Tarullo and Gunnar (2006, p. 632) note, the HPA axis (consisting of the hypothalamus, the anterior pituitary gland and the adrenal cortices) "constitutes one of the principal pathways of the mammalian stress response, in which a cascade of events leads to elevations in glucocorticoid hormones". When a mammal is faced with a stressor the hypothalamus increases the amount of corticotropin releasing hormone (CRH) and arginine vasopressin (AVP) that it releases into the anterior pituitary gland. This gland responds by releasing adrenocorticotropic hormone (ACTH, which stimulates the adrenal gland to produce cortisol, a steroid hormone principally targeted at the brain. As Tarullo and Gunnar (2006, p. 632) note, cortisol is necessary for survival "but when it is chronically elevated or poorly regulated, it can have deleterious impacts on health".

Because the HPA system is not fully mature at birth, experiences play a fundamental role in shaping its basal rhythms and its reactivity. As Yates (2007) notes, the HPA axis is essential for effectively responding to stressful stimuli in the short-term but if these systems are repeatedly activated without recovery, as occurs when a young child is exposed to very high levels of unbuffered stress, the HPA axis becomes overactivated. As a result, this regulatory system "becomes more limited in its ability to manage new sources of stress, and other linked regulatory systems (e.g., the growth system, the immune system) do not function optimally" (Bugental & Grusec, 2006, p. 413).

As Yates (2007) points out, any alteration to these systems has the potential to negatively influence aspects of neurodevelopment such as synaptic pruning, dendritic branching, and neuronal death. Ultimately, the continuous activation of the HPA axis (and associated changes in the functioning of other aspects of the central nervous system) may lead to problems "not only in brain development but also in the social-emotional and cognitive functioning and the health and growth of the child" (Bugental & Grusec, 2006, p. 413).

Perhaps not surprisingly, then, the HPA axis has been shown to be very sensitive to adverse experiences with a primary caregiver (see, for e.g., Wismer Fries et al., 2005). As Read, Perry, Moskowitz & Connolly (2001, p. 327) point out,

> [s]elf-regulatory systems, such as the HPA axis, seek to return the brain to prestress levels of sensitivity to stress. However, repeated stressors can sensitize neurobiological process so that the homeostasis returned to is at a higher level of responsivity.

As Read et al. (2001) and Perry (2001) note, research has identified two interacting patterns of response to extreme stress in childhood. The first is the hyperarousal (the fight or flight) response where the brain stem and mid-brain neurotransmitter systems are sensitized, resulting in the child being

> easily moved from being mildly anxious to feeling threatened to being terrorised. In the long run, what is observed in these children is a set of maladaptive emotional, behavioral, and cognitive problems, which are rooted in the original adaptive response to a traumatic event.
>
> (Perry, Pollard, Blakely, et al., 1995, p. 277, cited in Read et al., 2001, p. 327)

The second response to traumatic events in childhood is 'dissociation' which involves decreases in blood pressure, and heart rate and "dissociative 'freeze' or 'surrender' responses. As Read et al. (2001) point out, while these responses may well be adaptive for the immediate situation this hypoarousal pattern cause difficulties for the child later on. As Perry (2001, p. 5) points out, "the predominant response patterns and combinations of these primary 'styles' appear to shift from dissociative (common in babies and young children) to hyperarousal during development. As Perry (2001, p. 8) further notes, "the child and adult response to trauma is an admixture of these two primary adaptive patterns, arousal and dissociation".

The impact of disrupted or problematic early relationships on neurodevelopment is vividly illustrated in children who have been the victims of neglect[11] or maltreatment[12]. A review by Cichetti (2003) notes that maltreatment of children in their early years results in marked changes to neurobiological and neurodevelopmental processes mediated by the L-HPA and NE-SAM systems. As Cichetti (2003) points out, these processes may be hypo or hyper activated due to these children's experiences and while the reasons for these variations are not yet fully understood, as has already been noted above, "both hypo and hyper stress reactivity have negative implications for development and adaptation" (Yates, 2007, p. 11).

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[11] Defined as consistent failure to meet physical needs (e.g., warmth, food, shelter, physical closeness, etc.) and/or relational needs (attention, respect, emotional warmth, boundaries, etc.).

[12] Defined as any consistent parental behaviour or control tactic that causes the child to experience stress (in both the psychological sense of fear and anxiety and the physiological sense of heightened cortisol levels, heart rates, etc.).

The results of a recent study by Wismer-Fries et al. (Wismer Fries, Shirtcliff, & Pollak, 2008, p. 596) shows that neglect has a similarly negative effect to trauma on the HPA system. As Wismer-Fries et al. (2008, p. 589) point out, "early social and emotional neglect is associated with disruption in the normal activity of the HPA system". These authors suggest that "failure to receive this type of external 'scaffolding' from adults may have long-term effects on the physiological systems underlying children's emotional regulation" (Wismer Fries et al., 2008, p. 589), particularly the HPA axis.

Such findings support Hofer's (1987) conclusion that the mother-child interaction helps to regulate developing biological systems. If the relationship fails to do this then the various systems the mother-child interaction is either directly or indirectly involved in regulating, including the stress response systems, will end up becoming 'dysregulated'.

As Perry (2000, p. 15) points out, "the organizing brain requires patterns of sensory experience to create patterns of neural activity that, in turn, play a role in guiding the various neurodevelopmental processes involved in healthy development". Research conducted by Perry and his team (Perry, 2000, p. 15) suggests that if a child's experience of life is chaotic and the sensory inputs are not consistent or predictable then "the organizing systems in the brain reflect this chaos and, typically, organize in ways that result in dysregulation". This finding is also supported by animal studies which indicate deficient biobehavioural self-regulation in rats and monkeys who have been separated for long periods of time, or permanently, from their mothers (Kraemer, 1997; Schanberg & Field, 1987, p. 1442).

While the majority of research has focused on children exposed to particularly traumatic stressors or global neglect there is growing evidence that "more subtle variations in the quality of early caregiving have salient effects on the organization of stress response systems" (Yates, 2007, pp 10-11). This suggestion is supported by research which shows that the cortisol levels of infants who are in 'secure attachment relationships', which are believed to develop through a history of sensitive care-giving, do not elevate, even when they are upset, whereas infants in insecure attachment relationships do (Gunnar, Broderson, Nachmias, Buss, & Rigatuso, 1996; Hertsgaard, Gunnar, Farrell Erikson, & Nachmias, 1995).

The results of a study by Gunnar, Brodersen, Nachmias, Buss and Rigatuso (Gunnar et al., 1996, p. 191), for example "confirmed and extended evidence that secure

attachment relationships protect or buffer infants from elevations in cortisol" with the authors noting that

> these protective effects have now been demonstrated to a wide variety of potentially threatening stimuli: inoculations, maternal separation, novel or strange people, and strange events.

The results of a study by Hertsgaard, Gunnar, Farrell Erikson and Nachmias (1995), on the other hand, found that the stress responses of children who have disorganised/disoriented attachment relationships (associated with care-giving which is unpredictable, inconsistent and/or severely missattuned) deviate markedly from normative stress responses. And as Pollak (2005), has shown, even simply interacting with 'sensitive caregivers' (as opposed to 'insensitive caregivers') with whom no 'attachment' has necessarily been formed, has been shown to prevent elevations in cortisol in situations that nonetheless cause distress or wariness in the child (Pollak, 2005).

Providing more support for the contention that children's stress response systems are affected by quality of care, a study by Dettling, Gunnar and Donzella (1999) found that the normal circadian HPA activity (staying much the same for younger children and decreasing as the day progresses in older children) was disrupted in children in full-day, out-of-home childcare settings. While the children were in care there was a slight rise in cortisol over the day, while samples taken at home on non-childcare days showed the normal daily pattern. As Gunnar and Cheatham (2003, p. 204) point out, perhaps not surprisingly, other studies have shown that daily CORT levels are strongly affected by the quality of care children receive in these institutions with children who "receive a lot of focused attention and stimulation from the careprovider . . . less likely to show this CORT rise" and more likely to show the same pattern of daytime CORT production that they do at home. These results suggest that it is not necessarily being away from the home that is stressful; rather it is the lack of focused attention and stimulation from someone who seems to care for them.

A study by Bugental, Martorell and Barrazza (2003, p. 237) found that even "subtle forms of maltreatment during infancy (below 1 year of age) have potential consequences for the functioning of the child's adrenocortical response system". For example, infants who received corporal punishment frequently showed "high hormonal reactivity to stress" (Bugental et al., 2003, p. 237). And infants who "experienced frequent emotional withdrawal from the mother (either as a result of maternal

depression, or mother's strategic use of withdrawal as a control tactic) showed elevated baseline levels of cortisol" (Bugental et al., 2003, p. 237).

Bugental et al. (2003) suggest "there are hormonal 'costs' when mothers show response patterns (intentionally or unintentionally) that limit their utility as a means of buffering the child against stress" (Bugental et al., 2003, p. 237). The authors further suggest that the

> hormonal responses shown by infants may alter the functioning of the hypothalamic-pituitary-adrenal (HPA) axis in ways that, if continued, may foster risk for immune disorders, sensitization to later stress, cognitive deficits, and social-emotional problems. (Bugental et al., 2003, p. 237)

This is in line with findings on the effects of maternal depression on children. A depressed mother is essentially emotionally unavailable to her child and is often unable to be responsive to their socio-emotional, and sometimes even their basic physical needs (Moehler, Brunner, Wiebel, Reck, & Resch, 2001; Murray, Fiori-Cowley, & Hooper, 1996). Depressed mothers, as well as mothers subject to panic disorder, are less responsive to infant distress than are nondepressed mothers and thus are less likely to buffer the young against stressful experiences (Bugental et al., 2003). Not surprisingly, children of such mothers are dysregulated in their production of cortisol (e.g., Bugental et al., 2003; Dawson & Ashman, 2000; Essex, Klein, Cho & Kalin, 2002; Field, 1994; Newport, Stowe, & Nemeroff, 2002). As Bugental et al. (2003, p. 238) point out, "when a mother is clinically depressed over a period of time, children may show physiological changes (e.g., changes in cortisol levels), accompanied by disruption of their social and emotional regulation capacities".

Such findings suggest that social relationships can buffer the stress reactions of the HPA and NE-SAM systems (Pollak, 2005). As Liu et al. (1997, p. 1659) point out, this suggestion is further supported by animal studies showing that "naturally occurring variations in maternal care in early postnatal life are associated with the development of individual differences in behavioural and HPA responses to stress in the rat" (e.g., Francis, Caldji, Champagne, Plotsky, & Meaney, 1999; Francis, Caldji, Champagne, Plotsky, & Meaney, 1999).

4.5. CONCLUSION

It is suggested that the developmental systems account of biology provided by Steven Rose and outlined in Section 4.2 begins the process of building a bridge between our bodies and our social/ psychological experiences in the world by providing an analysis of our biological development that acknowledges the complex interrelations between our bodies and the environments within which they exist. The research discussed in Section 4.3 illustrates and supports Rose's central point, that organisms cannot be understood separately from their environment and that we are all "the products of the constant dialectic between 'the biological' and 'the social' through which humans have evolved, history has been made and we as individuals have developed" (Rose, 1997, p. 6).

One of the key messages emerging from the research cited above, animal and human, is that early experiences with care-givers shape the infant's ability to regulate their responses to the world, and to stress in particular. [13] Indeed, researchers in the area of developmental psychopathology suggest that alterations in the HPA and/or NE-SAM systems may be one of the main ways in which early adverse life events impact on neurodevelopment thus leaving the person vulnerable to later psychological suffering (Korte, 2001; Pollak, 2005; Yates, 2007). The implications of this will be discussed in more detail in Chapters Five and Six.

[13] It must be acknowledged at this point, however, that much of the neurodevelopmental research cited in this chapter is, at this stage, still speculative and because we do not know the 'norms of reaction' – the points beyond which 'normal' development breaks down – human beings may be more 'plastic' and thus more resilient, than the very early specificity often implied by these accounts.

CHAPTER FIVE

TOWARDS A PERSON-BASED ACCOUNT OF PSYCHOLOGICAL SUFFERING

5.1. INTRODUCTION

> Without an understanding of the developmental processes, the procedures and methods by which competent adults are produced from our newborns . . . the disturbances people suffer in their being would seem to be impossible to understand also.
>
> (Shotter, 1984, p. 191)

In Chapter Three an approach to human psychology was presented which suggested that our personal being – those aspects of humans considered to be 'mental' or psychological – are essentially constituted out of the social interactions within which we are enmeshed during our early lives. In this view, "the human child does not develop psychologically according to the 'laws of nature', but in an intentional manner" (Shotter, 1984, p. 71). It was suggested that the picture of human beings sketched out in Chapter Three is more likely to provide the foundations of a theoretically coherent and practically useful account of psychologial suffering than the assumptions which, it has been argued, underlie the Dysfunctional Mind Account, as outlined in the Introduction.

As was pointed out in Chapter Four, however, the emergence of persons and their psychological suffering cannot be understood by looking only at sociocultural and discursive factors because persons are both socioculturally *and* biologically co-constituted. In order to facilitate a clearer articulation of the ways in which this co-constitutional process occurs a brief outline of the developmental approach to biology taken by Steven Rose (1997) was provided before discussing some recent research from the biological sciences which illustrates Rose's (1997) central contention – that the lifeline of an organism is constructed via its enmeshment in its environment, and thus cannot be understood without taking that environment into account – an insight which mirrors the

social constructionist position that a person cannot be understood separately from the social world within which s/he is enmeshed.

In this chapter I will sketch a very general outline of how such a biologically and socioculturally coconstitutive process may occur during development, and how vulnerabilities for psychological suffering may emerge from such processes. This outline will serve as a general template for more detailed analyses, to be presented in Chapter Six, of how, depending on the vagaries of each person's particular life trajectory, different kinds of psychological suffering – I will look specifically at how the two major 'mental disorders' of 'schizophrenia' and 'depression' – may emerge. The resulting analysis will, it is hoped, frame psychological suffering not as 'illness' or 'dysfunction' but, rather, as behaviours and experiences (many of which could more usefully be seen as adaptive strategies for dealing with the otherwise unbearable) which emerge from the living of human lives in a complex and sometimes inhuman world.

It should be noted that in the account presented here I will not be speculating about the role that genes may play in the genesis of psychological suffering. While it is acknowledged that it is possible, although this has by no means been proven beyond a doubt, that certain genetic profiles may make a person more vulnerable to suffering psychologically in certain environments, the position taken in this thesis is that it is the environment within which those genes are expressed, and within which a person lives out his or her life, that makes the crucial and decisive difference between a person experiencing suffering or not experiencing suffering. The same point applies *vis a vis* various other biological factors which have been the subject of much speculation from researchers attempting to find the 'causes' of 'mental illness' – for example, viruses, birth defects, birth trauma, etc..

Thus the focus of this analysis will not be upon a person's genetic make-up, or on any other biological 'vulnerabilities' which may increase a person's likelihood of suffering psychologically, *within a certain environment*, rather it will be upon the processes that do, and do not, occur within their social environment, and the effect of these on the development of a person's neurobiology and their emerging personal being. Indeed, even if it were to be found, beyond a shadow of a doubt, that people who were diagnosed with certain 'mental disorders' had particular genes or birth defects or viruses, or any other biological factor this still does not "warrant the adoption of an exclusively organic approach . . . What matters is how a person *lives out* their physical condition" (Ingleby, 1980, p. 39).

Thus, in this analysis, in agreement with a number of authors whose work I draw upon in this thesis (e.g., Ingleby, 1980 and Bentall, 2004), I am turning on its head the common approach to attempting to understand psychological suffering which sees biological abnormalities as creating the *necessary* conditions for such suffering and environmental factors merely increasing the risk that such suffering will eventuate. What I am suggesting is that environmental factors create the *necessary* conditions for such suffering although, as is acknowledged in this and the following chapter, that does not mean that those factors are sufficient, in and of themselves, for the kinds of suffering we conceptualise as 'mental disorder' to emerge. Rather, such suffering will depend for its emergence on the compounding effects of complex coactions between various aspects of a person's being in the world – molecular, organismic and personal[1] – and the social world within which they are enmeshed.

Because, as has been noted a number of times in this thesis, it is the 'person', rather than their biology, who lies at the centre of both the genesis and the experience of psychological suffering the focus of this account will be an analysis of the emergence of our 'personal being' (central to which are our 'senses of self') from our early social interactions, particularly those with our primary care-giver. This analysis will draw primarily on the work of Rom Harré, John Shotter, John Cromby and Russell Meares, theorists whose approach to human psychology was introduced in Chapter Three.

It should be acknowleged at this point that this analysis is essentially a 'developmentalist' one, a perspective which has been subjected to considerable criticism by a number of authors (e.g., Burman, 1994; Morss, 1996). Before proceeding any further I will briefly discuss some of the criticisms directed at 'developmentalism', and outline why, while many aspects of traditional developmental accounts will be rejected, the account to be presented in this thesis will nevertheless be a 'developmental' one.

Morss (1996, p. 49), in his evaluation of the critical psychology of development, defines 'developmentalism' as involving "the assumption of natural change". This change may be posited to occur in a series of stages through which the individual progresses or it may involve more general statements "concerning directional change during the human lifetime: for example, the proposal that adults are more rational or complex in their thinking than children"(Morss, 1996, p. 49). Developmentalism can also take the even more general form of 'Children are like X', 'Adults are like Y'. A

[1] I will discuss the different 'grammars' associated with these different aspects of our being in the world in Section 5.2.2.

developmental explanation, suggests Morss (1996, p. 51) " is always made for a purpose. Those purposes, and their moral contexts, are as varied as human social life allows".

As Morss (1996, p. 48) points out, it is necessary to establish a critical distance from all developmental explanations by acknowledging them as discourses – "coherent systems of meanings that are historically located and that reproduce power relations". A developmental statement – such as 'Peter is just coming into adolescence, that's why he's acting this way' or 'All adolescents act this way' can never, argues Morss (1996, p. 48) be seen "as a neutral 'reading-off". Rather, "[d]evelopmental change must always be treated as 'produced', so any naturalistic account of development has to be rejected" (Morss, 1996, p. 48).

Morss (1996) suggests that the social constructionist theorising of writers like Harré and Shotter has gone some way towards remedying some of the problems inherent in a traditional 'developmental' approach. Morss (1996, p. 47) notes, however, that such theorising has not gone far because while "there is little appeal to biological forms of adaptation [in their work] . . . a naturalistic argument is still to be found". Morss (1996, p. 47) suggests that for social constructionists,

> people's experience of their own and of others' lives can take place only through social interaction. Developmental change is refracted through interpersonal negotiation. Such social processes are treated as generically human ones. The image, perhaps, is of small communities in which much interaction is face-to-face and on equal terms. Such direct interaction is taken to guarantee equality and authenticity of communication.

It is acknowledged that Shotter and Harré may perhaps be interpreted as presenting, at times, an idealised picture of human social life wherein people socially construct their identities linking themselves, semiotically both to each other and to their surroundings (Shotter, 1984) as if each individual in this 'dance' were equal and the environment within which it was occurring was essentially benign. As the quote from Morss (1996) cited above implies (and, it should be noted, with which Shotter and Harré would not disagree), in other circumstances another dance would be danced and thus the kinds of social processes outlined by these theorists cannot be said to be 'generically human'.

There is no doubt that much of the criticism directed against 'developmentalism' provides a necessary check to the essentially absolutist claims made by traditional developmental psychology. There is a sense, however, that in their attempts to highlight the problems with the developmental approach, critics are throwing the developing

baby out with the developmentalist bathwater and arguing against the idea that anything at all can be described as 'naturally' or universally human.

Thus, while the particular set of social processes identified by Shotter and Harré, and outlined in this thesis, may not be 'generically human', in the sense that other, perhaps entirely different, social processes may occur in other situations, what *is* generically human is that social processes of some sort or another will always be constitutional of human 'being' and experience. As Small (1998, p. 14) points out

> our taxonomic order, the primates, is distinguished from other mammals by its intense sociality at all levels and especially by the necessary long-term affiliative relationship between parents and offspring.

And, as Taylor (2002) points out, of all the primates, humans are the most social of all. Our 'big brain', Taylor (2002, p. 36) suggests, is

> fundamentally a social brain. We live by our ability to coordinate our needs with those of the people around us . . . Our success as a species has come entirely from our gregarious nature. We live and work together, having found safety in numbers across the many thousands of years of our evolution.

While such a position is certainly 'universalist', in that it makes the assumption that all people share a fundamental property, it is not absolutist. It is not claiming that all people are all social in exactly the same way. As Colm Hogan (2000, p. xvii) points out, "there is a tendency to think of universalism as vacuous . . . as a matter of bare subjectivity [but] in fact, humans share many specific structures and properties, as the array of linguistic universals illustrates".

The position taken in this thesis is that Shotter and Harré's analysis has identified a number of important social processes a child (in this case, specifically, a modern, Western child) must be involved in for that child to learn the 'ontological skills' necessary to the achievement of what Harré defines as 'personal being[2]'. This is not to say, as will be discussed in more detail below, that these particular social processes happen, or should happen in every society at every time in history, or that they are better than any other social processes which may have occurred at any other time or place – a point which is fully acknowledged by both Shotter and Harré. Nor is it to say

[2] As noted in Chapter Three, 'personal being' encompasses (a) one's sense of oneself as a singular being with a continuous and unique history (b) one's capacity for self-reference ('self' consciousness), and (c) one's sense of oneself as an agent – "a being in possession of an ultimate power of decision and action" (Harré, 1984a, p. 29).

that the kind of 'personal being' achieved in the West is the only, or even the best, way of being available to humans.

If, within the context of a modern Western society, however, all, or even some, of the processes outlined in Chapter Three do not occur then this will, it is suggested, compromise a person's ability to fully, or in some cases even partially, participate in the social and material life of that society. This is not to pathologise those who find themselves in this position. Indeed one of the main aims of this thesis is to argue that such outcomes are not the result of 'disorder' or 'dysfunction' but are simply emergent from particular sets of coactions[3] between the organism/person and their social and physical environment. There is little doubt, however, that a failure of these basic social processes, in the absence of any remedial action[4], will often result in pathologisation of that person by the society within which they are living their life.

While the kind of interactions outlined by Shotter and Harré are, to a certain extent, particular to this time and place; what is not particular to this time and place, as has already been noted above, is the fact that a child, as a profoundly social animal (Blaffer Hrdy, 1999; Taylor, 2002; Small, 1998), must be involved, right from the start, in social processes of one sort or another, including, particularly in the early years, intense one-on-one interactions with a person (or, in the case of more 'traditional' societies, a number of people) who cares about them.

Indeed, the neurobiological research outlined in Chapter Four suggests that in early infancy a physically and emotionally close relationship between a child and at least one committed care-giver (usually the child's biological mother) *must* be established if the child is to develop in such a way as to enable them to participate in the social and material life of *any* society. As Kraemer (1997, p. 404) points out, such research suggests that "being mothered . . . is the most important thing for the psychobiological development of the infant".

While the symbiotic relationship between a child and his/her mother identified by Harré and Shotter may not occur in the same way in every situation, and indeed may be thwarted in many, Shotter and Harré's analysis provides us with a general outline of what needs to be present for the establishment of such a relationship, and what

[3] And it is never going to be possible to specify exactly what these were for each individual. It may be possible, however, to distinguish patterns and trends that may be, at least partially predictive, amongst groups of people.

[4] And I am not referring here only to 'professional' intervention. 'Remedial action' can be, and is, taken by family and friends and can, particularly if such action is early enough in a child's developmental trajectory, lead to more positive outcomes for the child than would otherwise have been the case (Masten & Obradovic, 2006).

processes will, ideally, occur within that relationship at a particular time in history and within a particular sociocultural context. This analysis provides us with a starting point for the task of understanding how we come to experience ourselves as 'persons'. Such understanding must, it is suggested, precede any understanding of how we come to suffer in the ways that we do.

Thus, while rejecting many aspects of traditional developmental accounts the account to be outlined here will still be a 'developmental' one. It will begin from the assumption that humans are, first and foremost, social animals and that social processes of one sort or another, initially those involving the infant and his/her first care-givers and later involving other people and institutions within the person's social world, are fundamentally formative, in the developmental sense, of their experience of being in the world – whatever that experience may be. Indeed, it is suggested that one cannot hope to understand the genesis or the maintenance of the kinds of experiences listed in the DSM as 'mental disorders' without taking a developmental perspective and how 'what came before' conditions the possibilities for 'what happened next'.

Furthermore, as signalled above, while this account focuses on the emergence of our personal being from our early relationships with other humans this does not mean that the reality of our embodiment, and the organismic and sub-organismic processes which occur within those bodies, can be left out of the story. While these processes may seem entirely unrelated to the social world from within which our personal being emerges they are, as was discussed in some detail in Chapter Four, as profoundly shaped by the social world as our personal being. Further, as I will attempt to illustrate in the current chapter, the functioning of these organismic and sub-organismic processes subserve, and thus affect and shape, our subjective experience and our ability to fully participate in the material and social life of the society into which we are born.

5.2. INTEGRATING THE VARIOUS ASPECTS OF PERSONS INTO ONE ACCOUNT: OVERCOMING SOME CHALLENGES

To develop the kind of account of psychological suffering being attempted here, however, throws up some considerable challenges, in particular the difficulties inherent in attempting to integrate two fundamentally different approaches to the study of

human beings – the social sciences (which study the sociocultural and psychological aspects of being human) and the biological sciences – both of which have their own separate ontologies and grammars. As Williams (2001, p. 23) notes, we have to "rethink the relationship between biology and society, and associated terms such as mind and body, without slipping into former reductionist or conflationary traps of the past". It is suggested that one useful way of attempting to do this is to view the biological organism/person as a 'dynamic system', as advocated by developmental biologist Stephen Rose whose views were presented at the beginning of Chapter Four.

A dynamic systems viewpoint offers not only the possibility of integrating the biological and the 'psychological' or 'personal' aspects of human beings into one coherent account, but it also offers the potential for reaching an understanding of those phenomena we think of as being 'psychological' – our sense of 'self', our beliefs, our thoughts, our motivations, our very 'minds' – as emergent from recursive coactions between a variety of components.

5.2.1. Persons as dynamic systems

A dynamic system essentially comprises a number of interacting components, all of which can potentially influence each other. These interactions may be physical, or they may involve an exchange of information. The interactions between systems components are mathematically non-linear and asymmetrical (Cilliers, 1998, cited in Horn, 2002; Lasser & Bathory, 1997) which means, as Horn (2002, p. 27) notes,

> a change in A might not effect a proportional change in B. In addition, A and B may have different-sized effects on each other. These aspects of complexity mean that very small changes can have large effects on the future functioning of a system. Conversely, what appear to be large changes within a system may actually only have small effects on the overall system.

As Lasser and Bathory (1997, p. 149) point out, an understanding of such psychological phenomena as individual differences is profoundly affected by whether you apply the logic of linear or non-linear mathematics.

> In terms of linear mathematics, large differences in adult characteristics, whether in terms of cognition or personality, can be assumed to result from large differences in childhood characteristics, whether genetic or environmental. In nonlinear mathematics no such assumption can be made. Two children may appear to be very similar and to come from similar environmental backgrounds, but they may end up being radically different from each other as adults.

The interactions between the various components of a system then feed back upon themselves either directly (a change in A causes a change in B which then changes A, etc.) or indirectly through a network of interactions. Feedback may be positive (which increases the effect of a change) or negative (decreasing the original signal). Positive feedback does not necessarily lead to results which are positive for the system. This feedback process can result in the emergence of patterns within a system which can prove very resistant to change. Paradoxically, the feedback mechanisms within a dynamic system can also mean that systems may change quite suddenly and, seemingly, unpredictably. In hindsight, however, it is possible to see a series of changes which led the system into a state of 'self-organised criticality' (Horn, 2002).

A particularly important aspect of a dynamic system is that novel forms emerge from the interactions of the various components within the system through the processes of positive feedback. These novel forms then affect interactions within the sytem, and may then become parts of the system themselves. As Granic and Hollenstein (2003, p. 644) note

> This process is known as *self-organization* and refers to the spontaneously generated (i.e., emergent) order in complex, adaptive systems.

Lewis (2000, p. 36) points out that self organization

> accounts for growth and novelty throughout the natural world, from organisms to societies to ecosystems to the biosphere itself. According to principles of self-organization, these entities achieve their patterned structure without prespecification by internal rules or determination by their environments, and human development is just one exemplar of a universal tendency toward higher-order coherence.

Dynamic systems are also open to influences from the wider environment (outside the system) and can adapt to changes which occur in this wider environment. Despite their highly adaptable nature, however, Cilliers (1998, cited in Horn, 2002) notes that large changes across the system may occur as conditions outside the system change. How a system adapts to change depends on what state the system is in when new information arrives from outside. As Granic and Hollenstein (2000, p. 644) note "the context or ecology in which the system is embedded is critical for understanding a DS[5] behavior".

According to Lewis (2000) there are a number of reasons for why the principles of self-organisation offer the promise of providing a coherent understanding of human

[5] Dynamic systems

development. First, self-organizing systems permit true novelty; "new forms spontaneously appear with time, entraining the interactions of the elements that gave rise to them" (Lewis, 2000, p. 39). Second, self-organizing systems become more complex over time. The increasing orderliness of dynamic systems results in the maintenance of more and more sophisticated arrangements of coordinated processes. This is done spontaneously in the service of adaptive functions.

Third, "global reorganizations occur at *phase transitions*, points of instability and turbulence where old patterns break down and new ones occur" (Lewis, 2000, p. 39). Phase transitions occur abruptly across the whole system, meaning that new configurations require the cooperation of all system components. As Lewis (2000) notes, this idea has two ramifications: (1) new levels of complexity appear discontinuously, as exemplified by developmental stages and (2) development is strongly influenced by small effects at phase transition points so that "new forms are not *determined* by their precursors" (Lewis, 2000, p. 39, author's italics).

Lewis (2000, p. 39) illustrates this point by giving the example of 'personality' transitions during early adolescence or early adulthood when "emotionally loaded life events can trigger massive reorganizations of personality and identity". As Lewis (2000) points out, a dynamic systems approach allows the "progressive, discrete, idiosyncratic, and unpredictable" nature of developmental change to be accounted for within one coherent explanatory framework.

Finally, self-organizing systems are both intrinsically sensitive and intrinsically stable. As Lewis (2000, p. 39) notes "they are exquisitely sensitive to aspects of their environments because of their propensity for feedback and coupling with other systems". Lewis (2000, p. 39) goes on to note that despite this sensitivity, developing systems are nevertheless

> actively self-perpetuating, partly because recurrent patterns of coordination increase the likelihood of their own recurrence. This is true of course in learning to walk, but it can also be seen in the resilience of individual coping strategies despite environmental impediments and novel challenges.

As Lewis (2000, p. 39) points out, viewing human development through a dynamic systems lens

> accounts for the creation of order from intrinsic processes, the increase in complexity over time, the emergence of true novelty within developing systems, transition points that permit both structural advances and individual diversification, and the capacity for self-correcting stability as well as sensitive adaptation to the environment.

As Fogel (2000, p. xi) points out, however,

> all the other disciplines that partake of dynamic systems thinking deal with concrete and measurable entities . . . [which] . . . can be counted, quantified and reduced to numbers . . . and are substantiated in actual entities of flesh and stone. The psyche – the complexity of human experience – is none of that, neither commensurate nor substantial. Psyche coexists with matter, lives in bodies and ecosystems, but it is fundamentally nonmaterial. Psyche is emergent at the very core of its ontology whether we have dynamic systems ideas about it or not.

Lewis (2000, p. 41) also makes this point, noting that most developmental research "falls between the muscles and the brain", and asks

> Can the psychological system be said to self-organize, literally, as well? Can a framework invented for the study of matter be borrowed for the study of mind?

If we dispense with the unnecessary and confusing notion of 'mind' as it is commonly understood (immaterial, but nevertheless an object-like entity to be studied), however, as do the social constructionist theorists whose analysis forms the basis of the account to be presented in this thesis, the notion of self organization appears well suited to describe the emergence of those aspects of being human which are understood as being 'of the mind'. Lewis (2000) calls these aspects 'psychological forms', while Martin, Sugarman and Thompson (Martin, Sugarman, & Thompson, 2003, p. 103) refer to them as 'psychological kinds', described in general terms as

> human subjectivity, understanding, actions, and experiences, the agentic reality . . . we regard as not reducible to sociocultural, biological, or physical levels of reality.

As Lewis (2000, p. 41) notes

> Self-organization . . . appears well tailored to describe the emergence of psychological forms, which are macroscopic and highly ordered which both emerge from and constrain interactions among their constituents.

These 'psychological kinds' or 'psychological forms' essentially comprise our 'personal being', as articulated by Harré (1984).

While I will not be attempting to build a formal dynamic systems model of psychological suffering, it is suggested that such a dynamic systems conceptualisation of persons provides a useful heuristic device with which to integrate the various 'aspects' of our being in the world – biological and social – thus better arming us to embark on the quest to understand how psychological suffering may emerge from the complex coactions which occur between these various aspects.

While such a heuristic device goes some way towards ameliorating many of the problems inherent in attempting to integrate two fundamentally different approaches to the study of human beings there are still, however, some challenges to overcome. As Harré (2002) notes, because social scientists and neurobiologists use completely separate ontologies and grammars when they are talking about human processes and behaviours, it is important to pay very careful attention to the way in which language is used when discussing the various aspects of human being in the world.

5.2.2. Persons, organisms and molecules: Different 'grammars' for different aspects of being

If psychology is to achieve its aim of understanding people, Harré (2002) suggests it would make use of three different 'grammars'[6] – a P (persons) grammar, an O (organisms) grammar and an M (molecules) grammar to refer to the three different aspects of human beings it focuses on. The titles of each of these grammars would "reflect the ontological presuppositions each embodies . . . Persons, Organisms and Molecules are basic . . . sources of activity in these [three] ways of describing human life" (Harré, 2002, p. 138). In this way, suggests Harré (2002), psychology could encompass our neurophysiological grounding, our embodiment as sentient organisms in a physical world and our meaningful, agentic activity within a social world.

As Harré (1999, pp 100-101) notes,

> choice of grammar makes a difference to which aspects of the world stand out for us. Choosing a grammar is rather like choosing a particular dye to stain a bacterium. With one dye one set of microstructures becomes visible, with a different dye another stands out. Each is there in the bacterium, but is available to a human observer only when stained.

Similarly, if we use a person-based grammar certain aspects of human existence stand out, while if we used a molecular grammar other aspects would stand out. Thus, when we use P grammar the aspect that stands out is persons acting and interacting in their social worlds. This grammar is person-centred and focuses on people's capacities, skills, and actions. This grammar also includes those aspects of our lives we often refer to as 'psychological' or 'mental' – for example, emotions, thoughts, dreams, decisions,

[6] Harré uses the word 'grammar' in the Wittgensteinian sense as "systems and clusters of rules ordering human activity" (Cromby, 2004a, p. 801).

beliefs etc.. In this grammar, Harré (1999, p. 102) suggests, a human being would be seen in terms of his or her standing "in relation to the networks of positions that constitute the local moral order". In the O and M grammars, however, the human being is an organism consisting of clusters of molecules and "in relation to material things and other organisms would be seen in causal relations".

When talking about the various aspects of our biological reality, however, M and O grammar are the appropriate grammars to use. As already noted above, our biological reality can be broken down into a number of 'aspects' (e.g., genes, cells, organ systems, organs and organisms). O grammar would be used when talking about the actions of organisms in the world. This grammar is organism-centred and focuses on the coactions of biological organisms with their environment. M grammar would be used when talking about sub-organismic processes, processes which go on 'under the skin' of the organism.

This means that not only must anyone wishing to understand psychological suffering acknowledge the multi-levelled, multi-directional complexity of the relationships between our physical bodies and the material and social world within which they exist, they must also acknowledge that the various phenomena involved have grammars appropriate to them and attempt, insofar as is possible, to ensure that there is no 'slippage' or confusion between these grammars. Such slippage often results in the kind of assertions, commonly made within the neurosciences, and within biological psychiatry, which conflate brain and 'mind' and imply that all the information we need about human beings and their suffering will be found by looking in more and more detail at the brain.

One way Harré (2002) suggests that the relationship between persons, organisms and molecules could be usefully explored by psychologists, and such 'slippage' avoided, or at least minimised, is through a task/tool metaphor "by which tasks defined in the terms of the P discourses are accomplished by the use of tools described in terms of the O and M discourses". Tasks, notes Harré (1999), "are defined in a goal-setting or means-end discourse" while "bodies and their organs are tools" via which tasks are achieved. Harré (2002, p. 163) suggests this 'tool/task typology' is well suited to "bridge the distinction between bodily organs as structured molecular clusters and people". As Harré (2002, p. 163) puts it "[h]uman beings in the molecular ontology are machines

with no moral attributes. Brains in the person ontology are tools for use in tasks[7] set discursively".

As Harré (1999, p. 106) points out, "tasks are not reducible to tools, in the sense that there is no way that the task to be performed . . . could be deduced from knowledge of the tool. The fit is too loose, the boundaries of possible employments too broad". Indeed, as Rose (2000, p. 251) points out, while "all aspects of our existence . . . are made possible by the framing limitations of physical and chemical processes . . . this does not entitle one to say, for any observed behaviour, that it is caused by such processes; rather, they have made it possible – along with many alternative possibilities". Attempting to suggest that the tools determine or cause the tasks is to mistake enablement for causation.

Thus, it is suggested that when talking about psychological suffering, which is an intensely person-based experience, one must primarily utilise a person-based ontology, and the grammar appropriate to it. This does not mean that organismic and sub-organismic processes cannot be included in the analysis but they must be discussed as tools necessary to the tasks involved in achieving personal being, rather than as representative of its essence. Thus not only can some forms of social constructionist psychology be compatible with the biological sciences (including neuroscience), but, for Harré (2002), as for Cromby (2004a; 2007), both approaches are necessary to understanding human psychology because

> [h]uman beings are present to the world and to each other in three forms: as persons, as organisms and as complex clusters of molecules. None of the grammars grounded in these ontologies can be dispensed with, and none can be extended to comprehend the others without incoherence.
>
> (Harré, 2002, p. 167)

There are two further points to make concerning the relationship between the various aspects of our being in the world and the language we use to talk about them. Firstly, the three grammars outlined by Harré (2002) are not just three different ways of saying the same thing. When one is talking, using P grammar, about a person who is feeling very anxious before going into an unfamiliar social situation this is not the same as talking, using O grammar, or M grammar, about the organismic (sweating palms, elevated heart rate, dilated pupils) and sub-organismic (enervation of the amygdala

[7] 'Tasks', in this sense, are essentially anything we do in the world at a 'person-level', from saying 'hello' to giving a speech at the UN, from eating an apple to participating in a four-course banquet. The fulfilment of such 'tasks' requires the learning of the various 'ontological skills' necessary to the achievement of personhood, as noted in Chapter Four (Section 4.3.4).

leading to the secretion of CRH into the HPA resulting in the release of CORT into the bloodstream) processes which are occurring during this experience.

As Martin, Sugarman and Thompson (2003) point out, while person-based phenomena are just as 'real' as organismic and molecular phenomena they are entirely different. They cannot be talked about in O and M grammars and still remain person-based phenomena. This does not mean that an understanding of the phenomena which require the use of O and M grammars is not important to the understanding of person-based phenomena, it just means that one cannot hope to gain a complete understanding of person-based phenomena if one attempts to reduce them to organismic or sub-organismic processes.

This is essentially because our 'personhood', or what Harré (1984) refers to as our 'personal being', is an emergent phenomenon arising, as Chapter Three made clear, from the immersion of the biological human organism in the physical and, most importantly, social world into which it is born. Our personal being, including our psychological suffering, is more than the sum of its parts, and thus cannot be understood by reducing it to those parts.

Secondly, it should also be noted that none of the various aspects of our being in the world (the molecular, the organismic and the person-based) are more 'fundamental' than the others in the sense that one can always begin the causal chain at that level and work 'upwards'. While the biological aspects of our reality may seem to be more 'basic', indeed it would be impossible to feel anxiety if one was not an embodied sentient organism, or if one's amygdala did not become enervated in response to environmental stimuli, anxiety before going into an unfamiliar social setting is not 'caused' by these things.

While one can talk in a linear causal way about certain aspects of our biological reality[8] this approach cannot be applied to person-based phenomena such as psychological suffering. Thus, one may be able to say, within a molecular ontology and utilising M grammar that enervation of the amygdala *causes* the neurons in the paraventricular nucleus of the hypothalamus (PVN) to secrete corticotropin-releasing hormone (CRH) into the system that connects the hypothalamus to the pituitary gland, etc.). One may also be able to say, within the organismic ontology using O grammar, that stressful stimuli *cause* sweating palms. Both of these causal statements, while

[8] Although as Rose (1997) has made clear, a linear-causal approach is not necessarily always the most appropriate approach even when dealing with biological phenomena.

obviously radically simplified, can still provide useful information and understanding about the phenomena under study.

As already noted above, however, one cannot say that enervation of the amygdala, or any other biological event for that matter, *causes* social anxiety. As was argued in some detail in Chapter Two, this kind of assumption is one of the major errors in biological psychiatry where it is commonly claimed that various biological events (e.g., low serotonin levels) *cause* various 'mental disorders' (e.g., depression).

Neither, however, can one say, within a person-based ontology and utilising P grammar that a person's anxiety is *caused* in any straightforward way by particular aspects of their sociocultural or psychological reality. In other words, one cannot say that a person's anxiety before entering a strange social situation is *caused* by the particular social setting, or that it is *caused* by the person's mother having been overly critical of them during their childhood, or that it is *caused* by the person suffering from a 'social phobia'.

As will hopefully be made clear in the discussion to follow, the coactions between human beings and their physical and social worlds impact in different ways on the various aspects of our being (the molecular, the organismic and the person-based) which then themselves 'coact' with each other. These coactions, out of which persons, and the psychological suffering of those persons, emerge, are too complex and multi-levelled to make simple A leads to B linear-causal statements. This complexity is one of the main reasons why studies which have attempted to challenge biological psychiatry's hegemony by showing that 'mental disorders' have 'social causes' often fail to provide the kinds of unequivocal results for which their authors may have hoped.

As Harré & Gillett (1994, p. 122) point out, "there are effects or forces that may be discerned in the activity of an agent and are attributable to social structures . . . but these effects and forces are misconceived if they are represented as being similar to those at work in Newtonian mechanics". As Harré & Gillett (1994, p. 122) further note,

> the relation of symbol to brain function and brain function to behavior is more subtle than a simple causal production. Conceptual structure, arising in discourse, both constrains and makes available ways of using information that equip an individual to take genuine initiatives in their life contexts.

This is not to say, however, that we cannot reach an understanding of some of the complex coactions that may have contributed to the person's psychological and physical state before entering the room full of strangers. Indeed, the primary aim of this

thesis is to begin the process of building the kind of conceptual framework concerning persons and their development that would enable just this kind of understanding.

Before proceeding with the task of sketching a preliminary outline of how vulnerabilities to the kinds of suffering conceptualised as 'mental disorders' may arise from within the early social interactions which forge our personal being, however, I will set the scene for this analysis by discussing some of the contextual factors which impact upon and fundamentally shape these interactions.

5.3. LAYING THE FOUNDATIONS FOR PSYCHOLOGICAL SUFFERING

While the main focus of the analysis being presented here will be upon the child's early interactions with their first care-giver, the wider socio-cultural milieu within which these interactions occur profoundly influences, and at times constrains and disrupts, the way in which parents parent. In this section I will briefly discuss some of the factors which impact adversely upon the way in which children are 'brought up' within Anglo-American cultures, both distal (the 'privatised self' and the 'privatisation of parenting') and proximal (adverse situations such as poverty, marital discord, ill health, psychological suffering, etc.), and which thus play an important foundational role in creating a vulnerability to psychological suffering.

5.3.1. The private, autonomous, separate 'self'

As was discussed in Chapter Three, from the very beginning of their lives children are immersed, firstly indirectly through their parents and, later, more directly, in the wider socio-cultural discourses of their society, and these discourses fundamentally shape their personal being. Perhaps one of the most central of these is the notion we have in the West that we are in possession of a 'self' which is private, inner, autonomous and essentially separate from others (Schumaker, 2001; Shweder & Bourne, 1984). As Crowley Jack (1991, p. 7) points out, this 'private' self "dovetails neatly with dominant ideologies in the United States – individualism and its fraternal twin, capitalism." Capitalism is of course, an economic system that requires, for its optimum functioning, that people function autonomously and make economic decisions in their own self-interest.

As Shweder (1984, p. 194) notes, this 'egocentric individualist' conceptualisation of the 'self' is very different from the 'sociocentric organic' 'self' of more traditional cultures. Generally speaking, in such traditional cultures people are

> linked to each other in an interdependent system, members of organic cultures take an active interest in one another's affairs, and feel at ease in regulating and being regulated. Indeed, others are the means to one's functioning, and vice versa.

Rosaldo (1984, p. 146) points out, for example, that among the Ilongot[9], in common with many tribal cultures, there is no such thing as a 'private' or 'inner' self that is conceptualised as standing

> behind or underneath a public world where personhood is both affirmed and challenged. As numerous ethnographies suggest, our notions of a constant 'I' – alluded to by the experiences that make a lengthy dossier – are not found in tribal cultures in which kinship and identity are forever things to be negotiated in diverse contexts . . . Personal names may change when one contracts disease, moves to a new locale, makes friends, or marries. And character is seen less as a product of one's nature or experience in life than of the situations in which the actor currently is found.

Shweder (1984, pp 194-195) suggests that there are potential costs to be paid for valuing such a separate and autonomous notion of the 'self' because in doing so we are "cutting the self off from the interdependent whole" and making us more vulnerable to being isolated and/or lonely. This view of 'self' also makes it much less likely that people will be able to locate the source of their problems, or indeed of their very motivations and intentions (as was discussed in Chapter Three), outside of their 'selves'.

This, in turn, makes it more likely that they will blame themselves for their problems. Indeed, there are a number of discourses in the West around 'personal responsibility' that overtly encourage this, thus providing fertile soil for the 'negative attributions', 'low self-esteem', and feelings of guilt which are so central to many 'mental disorders' in the West (Schumaker, 2001). If something goes wrong, or our life is not working out as we planned, we have no one to blame but ourselves.

Shweder (1984, pp 195) suggests that because we have no larger framework within which to locate our 'self'

> Many in our culture lack a meaningful orientation to the past. We come from nowhere, the product of a random genetic accident. Many lack a meaningful orientation to the future. We are going nowhere – at best we view ourselves as 'machines' that will one day run down. The social order we view as the product of our making – an 'association' based on contract and individual consent. In our view, society is dependent on us . . . Cut

[9] A tribe that inhabits the east side of Luzon Island in the Philippines.

> adrift from any larger whole, the self has become the measure of all things, clutching to a faith that some 'invisible hand' will by sleight of hand right things in the end.

Not everyone will end up feeling like this, of course, but such an orientation establishes a vulnerability to such 'existential penalties', and these 'penalties', in turn, leave us more vulnerable to the kinds of suffering conceptualised as 'mental disorders'. That is not to say that people with more 'relational' conceptualisations of the 'self' would not feel sad, that they would not feel guilty, that they would not feel hopeless, that they would not have delusions, or hallucinations, etc.. Anthropological research suggests, however, that without the insular, privatised, autonomous and essentially separate Western 'self', these sufferings would be interpreted quite differently (Kleinman, 1988; Shweder, 1985; Shweder & Bourne, 1984).

For example, Kleinman and Good (1985, p. 3) note that

> "dysphoria" – sadness, hopelessness, unhappiness, lack of pleasure with the things of the world and with social relationships – has dramatically different meaning and form of expression in different societies. For Buddhists, taking pleasure from things in the world and social relationships is the basis of all suffering; a wilful dysphoria is thus the first step on the road to salvation. For Shi'ite Muslims in Iran, grief is a religious experience, associated with recognition of the tragic consequences of living justly in an unjust world; the ability to experience dysphoria fully is thus a marker of depth of person and understanding . . . Describing how it feels to be grieved or melancholy in another society leads straightaway into analysis of different ways of being a person in radically different worlds.

Furthermore, such experiences would also be conceptualised very differently by those around the person who was suffering, thus leading them to respond differently to them, which in turn would affect the trajectory that their experiences would take. This is illustrated by the oft-repeated finding that the 'prognosis' of 'schizophrenia', which is often a chronic and debilitating 'illness' in the West, is much better in developing countries (Warner, 1985). Indeed, as will be discussed in more detail in Chapter Six, such findings raise questions about whether the cluster of experiences conceptualised as 'schizophrenia' in developing countries may differ quite considerably from those experienced in Western countries. The same point can also be made regarding the cluster of sufferings conceptualised as 'depression'.

For a Westerner the kinds of suffering which comprise the various 'mental disorders' are considerably more likely to give rise to intense anxiety as they may potentially be seen as a fundamental threat to our sense of 'self' as a coherent, valuable, valued, and autonomous unity. They may also be seen as a threat to the potential autonomy and the 'success' of that self, particularly in light of the knowledge that,

ultimately, our life is our own business and if we 'fail' we must reap the consequences of that failure. As Schumaker (2001, p. 63) notes, the sociocentric or 'unindividuated' self found in non-Western cultures is "better able to locate problems at a less personal level" and thus is able to

> avoid the emotional brunt of these problems by coding stressful life events in external terms, or in the wider context of a collective identity. In a sense, the collective is able to absorb much of the emotional fallout.

This is not to romanticise the more 'relational' or 'sociocentric organic' self of non-Western cultures; as Shweder (1984) points out, there are often severe costs to be borne for having a more sociocentric self. This is particularly the case within contexts where serious power imbalances exist. What must be acknowledged, however, is that humans are, as has already been noted several times, profoundly social creatures. As Chapters Three and Four made clear we need contact with our fellow human beings at every level – molecular, organismic and personal – and if we do not receive that contact the consequences will be adverse. This means that the ideal of the autonomous, private and separate self which lies at the heart of our culture is essentially not a realisable one; we can never, as the highly social animals that we are, really be that 'self'.

But while very few people will actually have a sense of 'self' which matches the Western cultural ideal[10], the notion of such a 'self' nevertheless remains central to our culture and is reflected in the ways in which we are 'enculturated' by our families, and by our societies. As Shweder (1984, p. 194) notes

> our sense of personal inviolability is a violable social gift, the product of what *others* are willing to respect and protect us from, the product of the way we are handled and reacted to, the product of the rights and privileges we are granted by others in numerous 'territories of the self'.

Our right to 'privacy', for example, is just one of the ways in which our culture "asserts the sacredness of the person" (Simmel, 1968, p. 482, cited in Shweder & Bourne, 1984, p. 194) and these assertions are reiterated

> in the respect shown by a parent for a child's 'security blanket'. It's there as well when an adult asks of a three-year-old 'What do you want to eat for dinner?' and again in the knock on the door before entering the child's personal space, his private bedroom, another replica of the assertion.

As Shweder (1984, p. 194) points out, our view of our 'self'

[10] And, as Crowley Jack (1991) points out, seeing oneself as not possessing such a 'self' can, in and of itself, be a source of considerable suffering.

> is the product of the collective imagination. In the West, the messages implicit in many of our child handling practices may well socialize deep intuitions about the 'indecency' of outside (external) intrusions, regulations, or invasions of our imagined inviolatable self. Practices cultivate intuitions, intuitions about what's decent, which then support such Western notions as 'free to choose', 'autonomy in decision-making', 'sanctuary' and 'my own business'.

One of the major institutions for the enculturation of this sense of a private and personal self is, of course, the nuclear family, a child-rearing context that is, in common with the self it helps constitute, insular, private and conceptualised as 'nobody else's business'. I will now go on to discuss some of the implications of raising children within such a context.

5.3.2. The privatisation of child-rearing

The analysis to be sketched out in this chapter, and to be discussed in more detail in Chapter Six, suggests that intensive one-on-one interactions with the adults in their social world fulfil necessary developmental functions for a child on two 'levels'[11] of being – the biological and the psychological. At the biological level such relationships are essential to the regulation of an infant's basic biological functions and facilitates the eventual achievement of self-regulation of these functions (Hofer, 1987, 2001). At the psychological level such relationships facilitate a child's motivated intentions, providing the child with the skills to engage with the world of people and things (Cirulli, Berry, & Alleva, 2003), a process which allows for the emergence of personal being (which in the West essentially comprises our 'senses of self' as outlined in Chapter Three).

While the fulfilment of these functions at both levels is essential, no matter what sort of society a child is born into – whether it be a foraging society like the Efé Pygmy or a late-capitalist, technologically advanced society such as New Zealand – providing the level of care that will meet the needs of a human infant requires a considerable investment of time and effort. Indeed, the level of intensive and long-term care necessary to raise a human child exceeds that of any other animal on earth.

Because, however, the Western child is, to a very large extent, the responsibility of his or her biological parents, with the bulk of that responsibility being carried by the mother (Blaffer Hrdy, 1999; Lawler, 2000; Small, 1998), this places Western mothers in a

[11] The use of the word 'levels' is used interchangeably with the word 'aspects' and is not meant to imply that any level is any more fundamental than another.

very difficult position. As evolutionary anthropologist Blaffer Hrdy (1999) points out, Bowlby's (1969, cited in Blaffer Hrdy, 1999, p. 205) basic observations "that primate infants, including humans, are born immobile and vulnerable" and that "they respond very poorly to being left alone, or otherwise being made to feel insecure" cannot be disputed, and yet many Western mothers, for a complex mix of reasons, both socio-cultural and economic, cannot avoid leaving their babies alone, and/or without the opportunity for close contact and interaction with another human being, at least some of the time. Indeed they are often encouraged to do so by medical and childcare experts (Small, 1998).

In many traditional societies, past and present, however, the responsibility for the next generation was/is shared by a greater number of people (Blaffer Hrdy, 1999; Small, 1998). Such shared responsibility ensures a certain degree of autonomy for the mother, she can go out and work, as women have always done for the vast bulk of our evolutionary history, and it also ensures that babies and children are very rarely left alone (Blaffer Hrdy, 1999; Small, 1998). As Small (1998, p. 25) notes, cross-cultural studies show that the assumption, common in modern Western societies, that the "monotropic bond – that is, one parent at a time connected to one baby at a time" provides the best environment for a developing child, is, quite simply, wrong.

Studies by Tronick and his colleagues (e.g., Tronick, Morelli, & Ivey, 1992) have shown that an Efé pygmy infant spends 50 percent of its time with an adult who is not its mother during the first four months of its life, and also that the infant will interact with five or more adults per hour. Women other than their mothers also often nurse Efé pygmy babies. While the baby clearly knows who its biological parents are it has a wide circle of concerned adults to depend upon. As Small (1998) points out, "this multifaceted bond produces a tight network of social relationships – babies are attached to several adults and adults are attached to several babies".

While the Efé are particularly communal in their approach to child-rearing humans are, by 'nature', cooperative breeders and, up until relatively recently, the survival of our infants has depended on the mother being assisted by others – the father and/or various individuals (usually kin and, in humans, most commonly older, post-reproductive women) other than the parents – *alloparents*[12]" (Blaffer Hrdy, 1999, p. 90). In many primate societies the assistance of alloparents allows the females to breed much faster than they would otherwise be able to and "among humans living in foraging

[12] Edward O. Wilson's term for those individuals who help others rear their young: *allo* (from the Greek for 'other than') plus *parent* (Blaffer Hrdy, 1999).

societies, a helpful mate and/or alloparents were usually essential for a mother to rear *any* infant at all" (Blaffer Hrdy, 1999, p. 91). Research consistently shows that human beings require extensive socio-emotional support in the raising of their children and that if this support is not available the consequences for the child-care-giver relationship and the child's subsequent socio-emotional and physical development are likely to be adverse as will be discussed further below.

Indeed it is this reality that is often left out of the heated debates over what children 'need' and what mothers 'should' provide for their children. One side of this debate claims that a woman is a 'bad mother' if her whole life is not bound up in the needs of her child (e.g., Winnicott, 1964, cited in Lawler, 2000) while the other groups suggests that infants and children are, as Blaffer Hrdy (1999, p. 492) puts it

> innately flexible and resilient ready-formed personalities waiting to emerge, for whom 'good enough' care suffices in a world where it is considered crass to ask anyone to define what 'good enough' means.

Such polarised positions are almost inevitable in a world which is full of "conflicting self-interests – between parents and offspring, between mothers and fathers, within families, between families" (Blaffer Hrdy, 1999, p. 493) but they do not negate the ultimate reality that the "needs of human infants are enormous and largely non-negotiable" (Blaffer Hrdy, 1999, p. 493). What is negotiable, of course, is who will fulfil those needs and at this present point in history, conflict notwithstanding, it is still the mother who is ultimately positioned as the one who bears the most responsibility for this.

This means, of course, that women are also positioned as the ones to be blamed if something goes wrong. Indeed it has been this perceived 'mother-blaming' which lies at the heart of the conflict described above and it is not surprising, as Blaffer Hrdy (1999, p. 494) notes, that if infants' needs are presented as ultimately having to be met by mothers that some women may feel "compelled to downplay infant needs". It is also not surprising, given this context, that biological explanations for psychological suffering have eclipsed earlier explanations that were perceived to be 'mother-blaming'.

While the analysis being presented in this thesis could be construed by some as 'mother-blaming' there is no way around the fact that children's needs are indeed 'enormous' and they must be met to at least some degree or there will be adverse outcomes, as will be discussed in some detail below. I am focusing on the mother child relationship because, within the modern Western context, this relationship is the

primary location where such needs are almost always met (or not met) during the early years of a child's life.

This is not to say that mothers should necessarily be the ones to meet all of those needs. Indeed, it is suggested that such a requirement, in light of the kind of animals humans are, is entirely unreasonable and indicates there are major problems with the way in which, society-wide, we approach the raising of the next generation. Such problems are outside the purview of this thesis, but they are central to reaching any kind of understanding concerning why the problems between mothers and their children discussed below actually occur. Further, it is suggested that these problems must be acknowledged and addressed before any real progress can be made in preventing the occurrence of such 'failures' and the vulnerabilities to psychological suffering they confer.

Thus, because of the privatisation of child rearing in Western societies, with most of the responsibility being borne by the mother, there are often very few other people who are able to step into the breach if things go wrong. This means that a 'breakdown' in the mother-child relationship is likely to have particularly adverse consequences for the child, as will be outlined in more detail in Section 5.4. This is because such a breakdown leaves the child with little or no chance of learning the ontological skills required to engage with their social world.

A failure to learn such skills will almost inevitably create difficulties learning to negotiate their way around that world and may slow or even stop the process of acquiring the 'senses of self' that comprise our 'personal being' in Western societies. In addition, neurobiological research suggests that difficulties in the mother-child relationship will be very likely to alter the developmental path of the 'tools' that subserve this process in ways that leave these 'tools' less able to assist the child to regulate their emotions and their responses to stressful[13] events, as will be outlined in more detail below[14].

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[13] In this thesis the word the word 'stress' is used to refer to both physiological stress and the person-level experiences of, and responses to, that stress. Thus, for example, the phrase "an event which places a person under stress", essentially means any event which initiates the physiological stress response and the associated person-level or psychological experiences such as anxiety and/or fear, constricted attention, irritability/anger and etc.

[14] It should be added, however, this does not mean these 'tools' should be conceptualised as 'dysfunctional', at least in the sense that word is used within the DMA. A person's neurobiological 'tools' are shaped by the environment within which they spend their formative years and are often highly 'functional' within that particular environment having 'adapted' to help the child survive within it. As the person moves out into the wider world, however, their neurobiological tools may no longer be suited to the tasks they need to fulfil to become a participating member of their society. It is suggested that the neurobiological 'tools' of children growing up in an environment where they are exposed to events which cause them chronically high levels

In addition to increasing a child's likelihood of being adversely affected by a breakdown in their relationship with their parents, and, in particular, their mother, the privatisation of parenting also results in children spending more time either alone, or out of physical contact with another human being. As the research outlined in Chapter Four made clear, such contact is essential to optimal biological and psychological functioning and it is possible that such basic and essentially society-wide deprivation may contribute towards a generalised vulnerability to the ever-increasing list of 'mental disorders' endemic to, and rapidly increasing in, Western and Westernising societies (Good & Kleinman, 1985; Schumaker, 2001; Seligman, 1990).

As Small (1998, p. 223-224) points out

> human infants are evolutionarily – that is biologically over generations – designed to be part of an intimate physical dyad with an adult. Cross-cultural studies, observations of non-human primates and historical fact all combine to paint a portrait of a human infant entwined with a parent.

As Small (1998) further notes, perhaps one of the most important points about life within the kind of hunter-gatherer bands that shaped our modern 'humanity', and, importantly, the 'expectations' of our infants, is that in such societies babies are usually in constant contact with either their mother or some other human being. They are never left alone. The babies of the !Kung San of the Kalahari, for example, are with their mothers almost constantly, sitting in a special sling within the large animal-skin garment, the kaross, which women wear.

Indeed, Small (1998, p. 81) reports that anthropologist Melvin Konner "found that San infants have more than twice the amount of passive contact with their mothers than do babies in industrialized societies". Perhaps not surprisingly !Kung San babies rarely cry, and if they do it is not for long. As Small (1998, p. 81) notes, research shows that "more than 90 percent of their total crying events during the first nine months last less than thirty seconds".

Likewise, in the subsistence agriculturalist Gusii tribe of Western Kenya infants are always carried about during their first year, either by their mother, an older sibling or a 'child nurse'; usually a young female relative. Gusii babies, like the babies of the !Kung are never left alone and, as Small (1998, p. 95) points out "Gusii mothers cannot imagine leaving a baby in a room by itself, or leaving it alone to cry". Like !Kung San

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of stress will not serve them well in the wider social world particularly, and perhaps ironically, if they are exposed to stress.

babies, Gusii babies "are in physical contact with someone at least twice as much as white middle-class American babies" (Small, 1998, p. 105).

Thus, while human babies have evolved to require and to 'expect' intensive physical contact with one or more other human beings during their infancy, in modern Western contexts our infants are often left either entirely alone or with very little physical contact (while confined in buggies, car-seats, play-pens and high-chairs) with another human being for considerable periods of time (Small, 1998). Western infants even sleep alone whereas "in almost all cultures around the globe today, babies sleep with an adult and children sleep with parents or other siblings" (Small, 1998, p. 112). Indeed, as Small (1998, p. 112) points out this privatisation of sleep is "one of the major ways in which the West stands out from the rest of humanity in the treatment of children".

Of course the privatisation of child rearing, and the comparative physical/social isolation of our infants and children, does not mean that every one in the West will suffer in ways which would lead to them being diagnosed with a 'mental illness'. Many of us have parents who have managed, one way or another, to provide us with enough physical and emotional contact to enable us to make our way through life without coming to the attention of mental health professionals. Their interactions with us have facilitated our acquisition of the necessary ontological skills, enabling us to engage adequately with the world of people and things. The stability of their physical and emotional presence and their reactions to us have buffered us against stress and fostered resilience against future stress. Others, while their parents may not have been able to do this, may have had a grandmother, or an uncle, or an older sister who filled the gap, providing the interactions, the stability, and the love that the parents could not deliver.

What the privatisation of child-rearing does mean, however, is that modern Westerners are more vulnerable to failing to experience some, or many, of those crucial early interactions with significant others in our social world than those whose childhood is spent within more traditional hunter-gatherer or subsistence agricultural communities because if their biological parents are not 'up to the job' there is often no-one else who is able to compensate for them.

Thus, while most Western children will get by with considerably less physical contact during their early years than they are evolutionarily 'designed' for, those

children unlucky enough to receive parenting which is compromised in some way (often due to stress factors such as those discussed in Section 5.3.3 below) or those children who spend most of their time in out-of-home care situations where there is a high child to adult ratio and a low quality of care will be particularly adversely affected. Such children will not only receive even less physical contact than other Western children, but they will also receive less 'supportive' parenting in general, with many being subject to neglect and/or abuse.

In the following section I will discuss several more proximal factors that may impact upon parenting, leading, potentially, to the relational problems discussed in Section 5.4, which in turn, affect the developmental trajectory of the child.

5.3.3. Parenting under stress

As Francis et al. (1999, p. 1161) note, "human clinical research suggests that the social, emotional, and economic context are overriding determinants of the quality of the relationship between parent and child". As these authors go on to note, parental care is severely compromised if the parent is under chronic stress, and the "conditions that most commonly characterize abusive and neglectful homes involve economic hardship, marital strife, and a lack of social and emotional support" (Francis et al., 1999, p. 1161). Parental care is also severely compromised if the parent is suffering psychologically. There are, of course, a number of other stresses which impact upon parents in modern Western societies and may compromise their ability to meet the needs of their children[15] but space dictates limiting this discussion to a few particularly stressful situations.

Economic hardship

For a number of reasons one of the major stressors for a large number of people in the modern West is economic hardship and poverty[16]. Using longitudinal data from the Panel Study of Income Dynamics and the Infant Health and Development Program,

[15] For example, the necessity for (or desire on the part of) both parents to work at paid jobs, the pressures associated with work (e.g., demands to work longer hours, take work home, etc.), constant time pressure, parenting in urban environments where infants and children must be constantly under parental supervision, constant exposure to advertising and other inducements to buy goods and services, commercial and media influence upon children, etc.

[16] Poverty, of course, is not unique to the West; relatively speaking people are far poorer in the 'developing' world, although the context within which most non-Westerners experience poverty is considerably different. (Wilkinson, 1996)

Duncan, Brooks-Gunn and Klebanov (1994, p. 312-313) report that "[f]amily income and poverty status are powerful determinants of the cognitive development and behavior of children" even after other differences – in particular family structure and maternal schooling – between high and low-income families are taken into account. The authors also report that "the effects of persistent poverty were 60%-80% higher than the effects of transient poverty", suggesting that "the effects of poverty are cumulative" (Duncan et al., pp 312-13).

These authors suggest that "economic disadvantage not only has a tangible effect on children through the provision of educational resources available to them, but through the detrimental psychological effect it exerts on their parents" (Duncan et al., 1994, p. 315). As McLoyd & Wilson (1991, p. 107) point out, economic hardship has been shown to correlate with more punitive, and less supportive, parenting styles. Children who have been parented in 'non-supportive'[17] ways are consistently shown to have lower self-esteem, more antisocial aggression and behavioural problems, and higher rates of 'psychological disorders' than children who have been parented in more 'supportive' ways. Some of the possible reasons for such outcomes will be discussed in more detail in Section 5.4.

As McLoyd & Wilson (1991) further note, the fact that the kind of child-rearing practices more prevalent among economically disadvantaged parents (e.g., harsh discipline, nonsupportiveness) are predictive of a range of socio-emotional problems "strongly suggests that at least some of the psychological and behavioral problems of poor children are mediated by negative parenting precipitated by economic hardship" (McLoyd & Wilson, 1991, p. 112).

In support of this contention McLoyd and Wilson (1991) cite, Elder's (Elder, 1979, Elder Liker & Cross, 1984, Elder et al, 1985) studies of families during the Great Depression which indicated that

> fathers who sustained heavy financial losses became more irritable, tense and explosive, which, in turn, increased their tendency to be punitive and inconsistent in the discipline of their children. These fathering behaviors in turn predicted temper tantrums, irritability, and negativism in young children especially boys, and moodiness and hypersensitivity, feelings of inadequacy and lowered aspirations in adolescent girls
>
> (McLoyd & Wilson, 1991, p. 112)

[17] 'Non-supportive behaviour' is defined by McLoyd and Wilson (McLoyd & Wilson, 1991, p. 111) "as low levels of behavior that make the child feel comfortable in the presence of the parent and communicate to the child that he or she is basically accepted and approved".

More recent studies of contemporary children in families experiencing economic loss report findings consistent with Elder's mediational model (Galambox & Silbereisen, 1987; Lempers, Clark-Lempers & Simon, 1989, Silbereisen, Walper & Albrecht, 1990, cited in McLoyd & Wilson, 1991, p. 112). As McLoyd and Wilson (1991, p. 111, authors' italics) note, observations of mothers and children interacting over the course of several days

> indicated that day-to-day fluctuations in the mother's tendency to initiate and continue aversive exchanges with their children were systematically related to the *daily* frequency of hassles or crises that the mothers experienced.

As these authors point out, this strongly suggests that the ongoing stress of living, and attempting to raise children, in poverty, is a major reason why poor mothers "are less nurturant, less supportive, and less inductive in their parenting than middle-class mothers" (McLoyd & Wilson, 1991, p. 111). Further, as McLoyd and Wilson (1991) note, poor mothers are often fully aware of how their negative feelings towards life are affecting their parenting behaviour. As the respondents in a study by Longfellow et al. (1982, cited in McLoyd & Wilson, 1991) reported, it is difficult to behave in the ways required to be a good parent – nurturant, patient and involved – when you are feeling depressed and are under a lot of stress. Further, poor mothers were also fully aware that their 'parenting strategies' were ineffective and needed to be changed.

Perhaps not surprisingly, another factor that impacts on the way poor women parent is that they are considerably more likely to experience 'mental health problems' than their economically more well off counterparts (McLoyd & Wilson, 1991, p. 108). Studies indicate that prevalence of maternal depression among women living in poverty, for example, is twice that of women who are not under economic stress (McLoyd & Wilson, 1991). Such problems, as will be discussed in more detail below, have been consistently linked with difficulties with the relationship between the mother and the child and adverse outcomes for the child.

McLoyd and Wilson (1991, p. 108) suggest that "poverty, in addition to exposing the individual to more acute and chronic stressors, weakens the individual's ability to cope with new problems and difficulties, which, consequently, have more debilitating effects" (McLoyd & Wilson, 1991, p. 108). It should also be noted that poor mothers are also very likely to have been brought up in 'unsupportive' environments themselves, thus, as will be outlined below, making them particularly vulnerable to later psychological suffering.

Thus, as McLoyd and Wilson (1991, p. 128) stress, while they emphasize the role of mothers as a mediator of the impact of poverty on children's mental health, they

> do not blame mothers for the mental health of their children. Rather, both mothers and their children are seen as victims of economic and social inequality. Ultimately, it is poverty itself that creates suboptimal conditions for maternal psychological functioning, child rearing and child development.

Lack of social support

As has already been noted above, human beings are 'cooperative breeders' (Blaffer Hrdy, 1999) and require assistance from other human beings to rear their children. Research suggests, perhaps not surprisingly in the light of the privatisation of child-rearing noted above, that one of the most important sources of social support for parents in the West are their spouses or partners (Belsky, 1984, p. 88; Crnic, Greenberg, & Slough, 1986. p. 29; Gjerdingen, Froberg, & Fontaine, 1991). Indeed, Belsky (1984, p. 88) suggests that "the marital relationship serves as the principal support system for parents", a position borne out by the results of a study by Crnic, Greenberg and Slough (1986. p. 29) who found that of all the sources of social support the intimate support provided by a spouse or partner was the most powerful predictor of both mother and infant functioning[18] at both 8 and 12 months.

In line with this, research consistently indicates that growing up without two parents is associated with a host of adverse outcomes for children (Duncan et al., 1994; McLoyd & Wilson, 1991; Musick & Meier, 2008). Such outcomes strongly suggest that two people are able to do a lot better than one when it comes to raising the next generation. Not only can they offer each other social and emotional support, they can also share parenting duties, thus ensuring that neither one of them has to bear the entire responsibility for the well-being of their children alone.

Further, if the load is spread between two people then this can buffer the effects of any problems that may arise with one of the parents. For example it has been found that "involved, psychologically healthy, and supportive fathers can buffer children from the detrimental effects of maternal depression, whereas absent or psychologically unhealthy fathers can amplify the effects" (Goodman & Gotlib, 1999, cited in Shonkoff and Phillips, 2000, p. 254).

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[18] As measured by mothers' responses to the Satisfaction with Parenting Scale and the General Life Satisfaction Index, ratings of mother-child dyadic synchrony, infant compliance and non-compliance with mothers' requests. Infant 'attachment' was classified using Ainsworth, Blehar, Waters and Wall's (cited in Crnic et al., 1986) categories of 'avoidant', 'ambivalent' and 'secure' and infant 'competence' was measured with the Bayley Scales (Bayley, 1969, cited in Crnic et al., 1986).

The advantages of being brought up by two parents are removed, however, if there is marital conflict. Such conflict, of course, means that neither partner will be of any support to the other in raising the children, indeed their relationship will be a source of stress rather than support. Research suggests that children whose parents are together but often argue fare just as badly as those who are being brought up by just one parent with research suggesting that parental conflict is associated with negative schooling outcomes, behaviour problems, early and nonmarital family formation, lower quality adult relationships, and lower psychological well-being (Musick & Meier, 2008; Peterson & Zill, 1986; Reid & Crisafulli, 1990). Outcomes are, not surprisingly, even more adverse for those children whose parents' relationship involves violence of any sort (Jouriles, Murphy, & O'Leary, 1989; Holden, 1991).

The adverse outcomes for children often associated with single-parent families are particularly illustrative of the difficulties involved in attempting to bring up children without any social support. As Eisenberg (1990, p. 11) points out, "single mothers of whatever age, beset by poverty as well as by lack of emotional support from a husband, have difficulty meeting the needs of their children". As Musick and Meier (2008, p. 2) note, "growing up without both parents is associated with a host of poor child outcomes".

Children from single parent and stepparent families, for example, tend to end up with lower levels of educational and occupational attainment than children who grow up with both their parents and they also "report greater substance use and risk-taking behaviour, such as smoking, drinking, and drug use (Musick & Meier, 2008). As McLoyd and Wilson (1991) point out, if you add poverty to the equation outcomes are even worse. In comparison to children living in non-poor, two-parent households, for example, children in poor female-headed households have an admission rate to psychiatric outpatient services that is two to four times higher (Belle, 1980, cited in McLoyd & Wilson, 1991).

Single motherhood is also a risk factor for psychological distress in the mother, which, as will be discussed below, correlates highly with adverse outcomes for children. Anxiety, depression, and health problems are more prevalent among single mothers than they are among other marital status groups, and single mothers' risk of physical and psychological problems is intensified if they are poor and live alone with their children" (McLoyd & Wilson, p. 108). This further supports the contention that attempting to bring up children with very little social support is highly stressful.

Sources of social support outside the nuclear family include grandmothers, friends, neighbours, mother-child groups (often formed through child-birth education or early post-natal education classes), and the various 'experts' whom they consult concerning parenting, including GPs and Plunket nurses. A number of studies suggest that being able to draw on such sources of support is beneficial for both the mothers and their children. Grandmothers, for example, can provide an "important source of child care during the earliest months and years of life" (Shonkoff & Phillips, 2000, p. 234). Furthermore, research also suggests that grandmothers are not only important 'attachment figures' in and of themselves, but that their support of the mother facilitates more secure infant attachment[19].

Sources of support outside the extended family can also improve the relationship between a mother and her child. A study by Jacobson and Frye (1991), for example, suggested that maternal support positively influences infant security with infants whose mothers had the home visits being rated as more 'securely attached' than infants in the control group.

A study by Crnic, Greenberg and Slough (1986. p. 29) of mothers with high-risk infants also found a relationship between social support and infant attachment, with the infants of "mothers who reported satisfactory intimate, friendship and community support during early infancy" being judged to be more 'securely attached'. Crnic et al. (1986) also found that "professional support was associated positively with the quality of home environment at 8 months" and also with greater maternal satisfaction with parenting. These results suggest that mothers perceived such sources of support to be helpful to their parenting.

A study by Hashima and Amato (1994, p. 400) illustrated the particular importance of social support for parents in poverty by showing that "poor parents who reported few sources of assistance to draw upon in a crisis were especially likely to report that they yelled at or slapped their children 'very often'". These authors noted that a number of studies have shown that "economic deprivation combined with a lack of social support creates an especially dangerous situation for children" and that "social

[19] As was noted in Chapter Four (Footnote 7), while I will be drawing on research findings from the 'attachment' literature, this does not imply a wholesale acceptance of attachment theory as articulated by Bowlby (1969, cited in Hofer, 2001). Nor does it imply an acceptance that an infant's relationship with its mother can necessarily be neatly categorised into the various kinds of 'attachment relationships' that will be described in more detail below. Nevertheless, the findings from attachment research consistently show that certain sorts of behaviours on the part of the mother tend to be correlated with certain sorts of relationships between those mothers and their infants, and that the quality of those relationships then goes on to correlate highly with certain outcomes in later life. In this respect the findings from attachment research are useful in helping to support the analysis I am developing in this thesis.

support may play a special role in buffering poor parents from the stressful conditions of poverty and in decreasing the incidence of problematic parental behaviour" (Hashima & Amato, 1994, p. 400).

Research indicating that social support protects women from post-natal (also referred to as post-partum) depression also highlights the importance of such support, particularly in the first few years of a child's life. Indeed, it has been suggested that post-natal depression may be linked to, or even caused by, a lack of social support and recognition for the motherhood role. While epidemiological studies in the West suggest that approximately 10% of women develop post-natal depression, Stern and Kruckman (1983, p. 1033) note that "a review of the ethnographic literature on childbirth shows remarkably little evidence for post-partum depression in non-Western settings". From their own observations, and from an examination of the cross-cultural literature these authors suggest that there are a number of common elements in the social structuring of the post-partum period that protect women from the experience of post-partum depression.

These elements include: (1) cultural patterning of a distinct post-partum period; (2) protective measures designed to reflect the vulnerability of the new mother; (3) social seclusion; (4) mandated rest; (5) assistance in tasks from relatives and/or midwife; (6) social recognition of new social status through rituals, gifts or other means. These authors further suggest that "a relationship exists between the strategies typically employed cross-culturally in the post-partum period, which serve to mobilize social support to the new mother, and post-partum mental health" (Stern & Kruckman, 1983, p. 1036). The experience of 'depression' in the US (and other Western cultures) may, Stern and Kruckman (1983, p. 1039, authors' italics) suggest,

> result from the relative *lack* of: (1) social structuring of the post-partum events; (2) instrumental support and aid for the new mother; and (3) social recognition of the role transition for the new mother.

A study by Harkness (1987) supports this suggestion, with the author noting that there seems to be no evidence that Kipsigis women in the rural Kenyan province of Kokwet suffer from post-natal depression, in contrast to high prevalence rates for women in the West. As Harkness (1987, p. 200) points out, the "cultural structuring of the postpartum period in Kokwet exemplified to a high degree of the components of social support described by Stern and Kruckman (Stern & Kruckman, 1983) as typical of many non-Western societies. Stern and Kruckman have suggested that social support

systems such as those in Kokwet serve to buffer against or prevent the experience of postpartum depression.

Distressed mothers

A number of children are being raised by mothers who are experiencing considerable psychological distress, often to the point of being diagnosable as 'mentally ill'. Perhaps not surprisingly, research suggests such mothers feel considerably less positive towards their children and act towards them accordingly.

As will be discussed further in Chapter Six, there is a large body of evidence suggesting that parental, and in particular maternal, depression is correlated with unsupportive parenting styles and adverse outcomes for children (Beardslee, Versage, & Gladstone, 1998; Downey & Coyne, 1990; Gelfand & Teti, 1990; Reck et al., 2004; Murray et al., 1996). Gelfand and Teti (1990, p. 331), in a review of the literature, note that depressed mothers have been found to be "often preoccupied and inattentive to their children". Furthermore, "dyadic exchanges between the depressed mother and her child have been observed to lack the sensitive reciprocity, synchronicity, and expressions of pleasure in each other's company often found in nondepressed mother-child pairs" (Gelfand & Teti, 1990, pp 331-332).

As Reck, Hunt, and Fuchs et al. (2004) note, "the behavior of depressed mothers is characterized by a lack of responsiveness, passivity or intrusiveness, less positive affect, more negative affect, and a less expressive mimetic behavior". Overall depressed mothers are reported to "lack empathy and emotional availability", and to have "a reduced ability to perceive the child's signals and interpret them correctly, and to react appropriately and promptly". This maternal unavailability and unresponsiveness is suggested to lead to difficulties in the mother-child relationship (Beardslee et al., 1998; Downey & Coyne, 1990; Murray et al., 1996) and to long-term socio-emotional difficulties for the child (Downey & Coyne, 1990; Moehler et al., 2001).

A review by Kaitz and Maytal (2005, p. 573) suggests that maternal 'anxiety disorders' are associated with potentially adverse outcomes for children. Kaitz and Maytal (2005, p. 573) conclude that the interactions between anxious mothers and their infants are "mutually dysregulating in the short- and long-term" and are a potential long-term "source of risk and distress" for the mother and the infant. Thus, mirroring the findings from animal research reported in Chapter Four, more fearful, anxious mothers, like the low licking, grooming and arched-back nursing mother rats, appear to

be less able to respond to their infant in ways which are conducive to the child's well-being.

While there is not a lot of research on the effects of other 'mental disorders' on parenting behaviours and attitudes, as Downey and Coyne (1990, p. 56) point out, if a parent is suffering psychologically, however that suffering may manifest itself, this exerts a detrimental effect on their parenting, and thus on their children. For example, "a number of studies suggest the children of medically or nondepressed psychiatrically ill parents were indistinguishable from children with a depressed parent" (Downey & Coyne, 1990, p. 56).

Downey and Coyne (1990) also found, in a meta-analysis of studies looking at the effects on children of parental depression or schizophrenia, that "despite inconsistencies across measures and samples, the school-aged children of affectively disturbed and schizophrenic parents showed similar deficits in comparison with matched or random control children" (Downey & Coyne, 1990, p. 53). Once again, some of the possible reasons for such outcomes will be discussed in more detail in Section 5.4.

It is also important to note that many women, while not necessarily suffering in a way that would result in them being diagnosed with a 'mental illness' are nevertheless suffering considerable distress due to personal and socio-economic problems. As was noted above in the discussions concerning economic hardship and lack of social support, such distress, not surprisingly, interferes with a woman's ability to devote the amount of emotional and physical energy required to provide the kind of care 'expected' by a human infant. Such compromised abilities to care, in a context where the mother bears the main responsibility for that care, is likely to lead to adverse outcomes for the child.

5.4. PATHWAYS TO VULNERABILITY

While there is obviously a fair degree of latitude regarding exactly how very early interactions between a child and their first care-giver(s) proceed, research strongly suggests that if there is no-one in the infant's environment who is able to be fully engaged with that infant in the kind of synchronous and symbiotic relationship outlined in Chapter Three then this constitutes a "violation of expectation" (Brazelton et al., 1975, cited in Small, 1998) and the stress response will ensue (Hofer, 1987).

While the details of these interactions may be different across different cultures (Richman, Miller, & LeVine, 1992) the human infant nevertheless has some basic expectations of care, that our mother will remain close by and provide us with warmth, food and tactile, visual, auditory and kinaesthetic stimulation, which must be met. Within Western cultures such needs are met within the context of a psychologically symbiotic relationship with a primary caregiver, which quickly becomes highly verbal in nature, while within other cultures they are met within a relationship wherein physical contact is more central (Richman et al., 1992).

As was noted in Section 5.3.2 most of the responsibility for providing such interactions for human infants in modern Western societies tends to rest with the biological parents, primarily the mother. Because of this it is suggested that the modern Western infant is more vulnerable to missing out on important aspects of such stimulation because it is more difficult for one, or even two, people to be in the kind of close and consistent physical and social contact with a child that human infants have evolved to need and to 'expect'.

Indeed, research consistently indicates that Western infants have considerably less contact with their mothers and other care-givers than infants from more 'traditional' hunter-gatherer or subsistence agricultural societies – the kind of societies for which humans have evolved to be particularly suited (Small, 1998). As Shotter (1984, p. 57) notes, human babies are essentially "adapted to a complete dependence upon an adult human being" and for things to proceed well during early infancy a relationship is required within which each member pays total attention to the other while they are together.[20]

In the following it will be argued that when a child does not receive the kind of physical and emotional interactions they are evolutionarily evolved to 'expect' then developmental processes will be initiated which re likely to confer upon the developing child, at both a biological and a personal level, a general vulnerability to the kinds of suffering currently conceptualised as 'mental illness'. It must be stressed at this point that there does not need to be gross neglect or physical or sexual abuse for such damage to occur, there just needs to be a 'failure of care'[21] to the extent that the child's basic biological and person-level needs and 'expectations' are not being met. In Chapter Six I

[20] As was noted in Chapter Three research suggests that such preoccupation with the infant is very common, for both mothers and fathers during the very early weeks of parenthood, although mothers are generally much more preoccupied than fathers.

[21] This phrase 'failure of care' is not being used to imply that the mother is a failure; it is simply a useful shorthand to encompass the wide range of problems that can occur within mother-child relationships.

will discuss some of the possible ways in which such general vulnerability, depending on what happens to the person over the trajectory of their 'lifeline', may result in the kinds of experiences that are thought to be 'symptomatic' of two of psychiatry's most high-profile 'mental disorders' – 'schizophrenia' and 'depression'.

It is important to note at this point that this general vulnerability does not necessarily mean psychological suffering is inevitable. Because human beings are essentially dynamic systems a very small event occurring at a pivotal time in someone's life may radically affect the trajectory of that life. And, as will be discussed in more detail below, it is not just the experiences themselves but the timing, the context and the meaning assigned to those experiences that will make the difference between someone suffering or not suffering.

5.4.1. In the beginning

Human babies are born with a range of orienting, approach and expressive behaviours that allow them to immediately 'join the conversation' around them. Some of these behaviours are 'innate', while others, as Polan and Hofer (1999a) have shown are learned before birth. Such behaviours then serve as the building blocks from which the kind of psychologically symbiotic relationship described in Chapter Three can be constructed. As Taylor (2002) points out, less than an hour after they are born babies draw back their head to look into the face of the person who is holding them and within the first few hours they will turn their heads in response to their mother's voice. After only a few hours human infants can imitate an adult's facial expression and very soon thereafter they can accurately reflect back another person's emotions. And from the first day of their life infants will move their body in synchrony with adult speech (Small, 1998, p. 36). The human baby, as Taylor (2002, p. 39) notes, "begins life primed to be social".

These behaviours and abilities allow for a rapid increase in responsiveness on the part of the infant towards its mother in the first few weeks (Meares, 2000) of its life. This growing responsiveness results in a qualitative change in the interactions between the mother and the infant over these first few weeks so long, of course, as the mother is adequately responsive towards the child (Shotter, 1984). Thus, as Small (1998, p. 37) points out,

> when babies and adults interact, they are partners in an interactive social dance in which they jointly regulate each other, and this dance is essential for the baby's social and psychological development.

While the participants in this 'dance' may be acting more as 'biological individuals' than as 'persons' at this stage, the infant nevertheless requires, at every 'level' of its being (molecular, organismic and personal-psychological), a physically and emotionally close relationship with someone who cares for them and who is able to devote a considerable amount of time to meeting their needs. At the molecular and the organismic level, as was outlined in Chapter Four, research suggests that the various primarily physical interactions (cuddling, rocking, eye contact, vocalisations, provision of milk, etc.) occurring within the mother-child relationship act as regulators of immature biological systems in humans such as control of sleep-wake states and self-regulation during sleep, thermoregulation, regulation of growth hormone levels, regulation of stress response systems, and possibly even regulation of breathing (Hofer, 2001; McKenna & McDade, 2005; Perry, 2000; Schanberg & Field, 1987; Yogman, Lester & Hoffman, 1983, cited in Small, 1998; Wexler, 2006).

If things are going 'well' within the mother-child relationship such 'biological symbiosis' would occur 'naturally'. The mother would, because of her positive feelings towards her baby want to cuddle, stroke, smile at, make eye contact with, rock, talk to and generally be with her baby, and would thus provide, without much conscious thought on her part, the kind of tactile, visual, auditory and kinaesthetic stimulation required by a human infant. Research has shown that touch is particularly important for an infant's developing regulatory systems. For example, a study by Feldman, Weller, Sirota and Eidelman (Feldman et al., 2002) suggests that skin-to-skin contact or 'kangaroo care' increases the ability of premature infants to regulate their physiological processes (e.g., sleep patterns, temperature and oxygen consumption) and has been associated with better 'attachment' relationships later in life.

Research with non-premature infants has also shown that touch is "an important feature of early care and normative development" (Calkins & Hill, 2007, p. 239). Jahromi, Putnam and Stifter (2004) found, for example, that while mothers touched their babies less and were less affectionate with at 6 months than they were at 2 months, and the use of distraction and vocalising increased, holding and/or rocking the baby while vocalising reduced distress in infants at both ages. Other research has shown that 3 month-old infants do not respond to a still face interaction, normally a stressful situation, unless the mother was able to touch them prior to such interaction periods

suggesting that touch reduced the levels of stress experienced by the child (Gusella, Muir, & Tronick, 1988).

Within the context of these very early interactions mothers will also be preparing the ground for the development of a more 'psychologically' or 'personally' symbiotic relationship between their infants and themselves by reacting towards their infants as "potential human beings . . . with human qualities and sensitivities" (Newson, 1979, p. 210). As was pointed out in Chapter Three, this assumption "is integral to [the initiation of] psychologically symbiotic exchanges" (Harré, personal communication, 1997, cited in Tissaw, 2000) because in acting as if her child is an intentional being whose actions have meaning she essentially scaffolds the emergence of just such a being.

For a significant number of children, however, their mothers are unable to initiate or maintain even the very early stages, this kind of stable, reliable and physically and emotionally close relationship (Fleming & Corter, 1988; Downey & Coyne, 1990; Mayes et al., 2005; Teti, Gelfand, Messinger, & Isabella, 1995). As was noted above, this can occur for a number of reasons, including the socio-cultural and socio-economic factors outlined in Section 5.3, the complex subjectivities of human beings, and the fact that our parenting behaviours are learned rather than 'instinctive'.

As research within the field of attachment theory has consistently shown, babies who are mothered in ways which are 'unsupportive[22]' often end up exhibiting behaviours which suggest high levels of anxiety, insecurity and ambivalence. Utilising an experimental procedure called the 'Strange Situation Paradigm[23]' Ainsworth (cited in Teti et al., 1995) (Ainsworth, 1985) identified three basic infant attachment patterns – 'secure' (Type B) 'insecure-avoidant' (Type A), and 'insecure-ambivalent' (Type C) which have been conceptualised by Main and Solomon (cited in Teti et al., 1995) as "coherent, organized strategies used by infants to access their attachment figures in times of stress" (Teti et al., 1995, p. 365).

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[22] Ainsworth (1985, p. 777) describes unsupportive mothers as "generally less sensitively responsive to infant signals and communications across all contexts throughout the first year". She further notes that such mothers were "especially conspicuous [for] their delay in responding to crying and their relative lack of tender, careful or affectionate behavior when holding the baby". It should be noted that I will often use the phrase 'Unsupportive parenting' in this thesis as a shorthand way of referring to behaviours that fail to meet the basic relational needs of the human infant as outlined in Chapters Three and Four. Such relational needs include the need for affectionate physical contact (hugging, stroking, rocking, holding etc.) and the need for the caregiver to be "responsive to infant signals and communications across all contexts" (Ainsworth, 1985, p. 777). 'Unsupportive parenting' also encompasses behaviour that is emotionally or physically abusive – from regular corporal punishment through to physical and sexual abuse. In most cases, however, the phrase will be used to refer to failures to meet relational needs rather than overtly abusive behaviours.

[23] A 21-24 minute procedure during which young children's behaviour is observed during separations from and reunions with their mothers.

Main and Solomon (1990, cited in Teti et al., 1995) added a fourth category that they called 'disorganized-disorientated' (Type D). As Teti et al. (1995, p. 365) point out, Type B attachment patterns have been shown to relate to "empathic, sensitive parenting" and Type A and Type C attachments to "insensitive, unresponsive parenting". Type D attachments have been found to be particularly common among infants from 'high-risk' environments "characterized, for example, by very low income, child maltreatment, or parental alcoholic consumption".

Such research suggests that the babies of such 'unsupportive' mothers tended, in comparison to babies whose mothers were more 'supportive', to cry a lot more, to respond less positively to being held by their mothers and yet to protest more when they were put down by, or separated from, them. Such babies were also "less responsive in face-to-face situations and less responsive to maternal commands" (Ainsworth, 1985, p. 776). They were also judged to be a lot angrier and more irritable.

This kind of 'unsupportive' mothering, in addition to being stressful for the infant in and of itself, also interferes with the child's ability to regulate its own emotional reactions, to 'self-soothe'. While babies begin to regulate their emotional responses very soon after birth by engaging in behaviours such as suckling to sooth themselves (Campos, 1988, cited in Repetti et al., 2002), a study by Van den Boom (1994, cited in Repetti, Taylor, & Seeman, 2002) showed that "parental nurturing appears to facilitate the development of these primitive coping behaviors". In this study an intervention which improved "maternal responsiveness, attentiveness and control . . . resulted in an increase in infant self-soothing behaviors" (Repetti et al., 2002, p. 345). Further, infants whose mothers did not take part in this 'intervention' showed a slight decrease in self-soothing behaviours between 6 and 9 months and were rated as being less securely attached to their mothers.

The 'quality' of the mother-child relationship, as well as generating differing behavioural and emotional person-level responses in the child, has also, as was outlined in Chapter Four, been shown to generate different responses at the biological level. For example, the cortisol levels of infants who are in 'secure attachment relationships' do not elevate, even when they are upset, whereas the cortisol levels of infants in insecure attachment relationships do (Gunnar et al., 1996). Furthermore, research has also shown that children who have 'disorganised/disoriented' attachment relationships (associated with care-giving which is unpredictable, inconsistent and/or severely missattuned) deviate markedly from normative stress responses (Hertsgaard et al., 1995).

Such findings are not at all surprising in the light of Hofer's research (Hofer, 1987), which showed that the mother-infant relationship essentially acts as a regulator of the infant's immature biological systems. As was noted in Chapter Four, an infant only needs to be left alone, or even just without physical contact, for a short period of time before the changes characteristic of the 1st or 'protest phase' of the 'separation response' as described by Hofer (Hofer, 1987) are initiated.

Such changes include, at the organismic-behavioural level, an increase in agitation and in vocalisation (crying) and at the organismic-molecular level an increase in heart rate, and also in cortisol and catecholamine levels, and a lowering of body temperature. Indeed, animal research has suggested that even relatively brief periods of separation, within the range of what could naturally be expected to occur, still had detectable effects on the development and the behaviour of the offspring (Coplan, Trost & Owens et al., 1998, cited in Yates, 2007).

Furthermore, as Hofer's (1987) research made clear, if the 'separation' from the mother continues for a long enough period of time the first phase of the 'separation response' "merges into the slow-developing changes of the so-called despair phase" (Hofer, 1987, p. 638) [also called the dissociation phase]. Hofer's (Hofer, 1987) research indicates that some of the behavioural signs of this phase are decreased social interaction and play, mouthing and rocking, hypo- or hyper-responsiveness, decreased or variable food intake and postures or facial expressions indicative of sadness. Physiological signs include a decrease in weight, sleep disturbances, a decrease in core temperature, oxygen consumption, heart rate, and growth hormone levels. While most children will receive some sort of attention before they move into this 'despair phase', some children may spend considerable periods of time in this state.

A child who is left alone long enough for the 'despair' phase to begin is placed under extreme physiological stress due to the complete and ongoing withdrawal of the multiple regulators inherent within the relationship between them and their primary care-giver (Hofer, 1987) and the impact of such stress, particularly if it occurs frequently, will be extremely adverse for their developing neurobiology. As was detailed in Chapter Four, in animals such separations result in a number of persistent abnormalities in multiple neurotransmitter systems and also seem to alter the structure of the brain (Wexler, 2006).

While the 'separations' engineered by researchers between animal mothers and their infants in no way capture the complexities involved in a human-mother child

relationship, research has confirmed that human infants find separations from their mother as aversive as any other infant mammal, whether those separations be actual (as in the mother not being there at all) or socio-emotional (the mother being there physically, but behaving in an unresponsive or hostile manner).[24]

Research has also confirmed that such 'separations' affect various aspects of the infant's developing neurophysiology (and, indeed, their physiology in general), in particular their stress response systems. It is also of interest to note that the same neurotransmitter systems affected by mother-infant separations in animal research have also been implicated in the genesis of psychological suffering by researchers looking for the biological 'causes' of 'mental illness'. These same systems are also involved in addiction to various drugs (Keverne, 2004).

Further, Hofer's research suggests that if a baby remains alone and uncomforted long enough for the 'despair' or 'dissociation' phase to begin this would exert effects not just on the baby's developing neurobiology but also on the development of their personal being, central to which is their sense of 'self'. While at this early stage there is no psychological or personal sense of 'self' which can feel 'rejected' or 'abandoned', it is suggested that those human infants whose caregivers are unresponsive or neglectful will, due to the frequent, and often lengthy, withdrawal of the various regulators inherent in the mother-child relationship, be placed in a state of disequilibrium which will be experienced, even if only at a very basic level, as emotionally aversive.

While the child may not 'remember' such feelings, or the experiences that gave rise to them, in such a way as to enable them to narratively reconstruct them, these feelings and experiences would nevertheless exert an ongoing effect, particularly if they occurred frequently. Indeed, as was discussed in Chapter Three, such experiences are, like all our experiences, quite literally, embodied (Damasio, 1994; Perry, 2001; Schwarz & Perry, 1994) in ways that exert their effect throughout every level of our being.

Because these 'memories' are embodied rather than discursively created, they can be formed from the very beginning of a child's life outside the womb. Indeed, it is possible such 'memories' may even be formed prior to birth. It follows that if a child's experiences during their early years are particularly aversive (due to ongoing

[24] It could be argued that human infants find any maternal behaviour that interferes with the meeting of their basic physical and relational needs aversive. For example, mothers who consciously make a 'project' out of being a 'perfect' mother are, in their own way, being 'unresponsive' to their infant's needs if their interactions are imposed upon the child and are, in essence, motivated more by their own needs than by those of the infant.

'unsupportive' parenting) or traumatic (due to ongoing abuse for example) then the reactivation of their early memories would be particularly stressful at both the biological and the personal level.

Thus, as was pointed out in Chapter Three, this very early stage of the mother-child relationship, even before it becomes truly 'psychologically symbiotic', is a crucial one and if there are difficulties within the relationship then the consequences for the child are likely, at every level, to be adverse. It is suggested that if the relationship cannot be 'mended' in some way then such difficulties not only compromise the 'quality' of the mother-child relationship into the future but also lay the foundations for the kinds of suffering conceptualised as 'mental illness'.

5.4.2. Psychological symbiosis

As Shotter (1974b) and Tissaw (2000) point out, the relationship between a mother and her child becomes 'psychologically symbiotic' when behaviours such as smiling and reaching for specific objects "result in attempts on the part of the mother to interpret and/or complete what appear to be intentional or other actions that may be described through use of psychological predicates" (Tissaw, 2000, p. 856). As has already been noted, for a mother to do this, she must be able to orient towards her infant as if the infant was a 'person'.

Such an orientation, would be considerably more difficult to achieve if the mother was experiencing psychological distress of any kind. This suggestion is supported by the results of a study by Feldman (1999) indicating that depressed mothers were less likely to make attempts to build a personal relationship with their child. Such mothers were a lot less likely than 'healthy' mothers to use a nickname for their child, to idealise the child, to see resemblances between the child and other family members, to interact with the child in a special way or to imagine their child's future.

It is further suggested that a distressed mother would be less likely to be able to fully engage in the kind of 'proto-conversational' interactions outlined in Chapter Three. This suggestion is supported by the results of a study by Lundy (2003) which suggest that the frequency of 'interactional synchrony' the "extent to which an interaction appears to be reciprocal and mutually rewarding" (Isabella, Belsky & von Eye, 1989, p. 13, cited in Lundy, 2003), significantly predicts infant-mother and infant-father

'attachment security'. The results of this study also suggest that "individual differences in the frequency of such synchrony may be associated with differences in general perspective-taking skills" (Lundy, 2003, p. 201). Such 'perspective-taking skills' are conceptualised by Lundy (2003) as reflecting the ability of parents to be perceptive of their infants' 'mental processes'. Such 'perspective-taking-skills' could also be conceptualised, in less mentalistic terms, as the ability of parents to see their infant as a 'person'.

As was pointed out in Chapter Three, when things are going well between a mother and an infant they rapidly "come to coordinate their emotions and expressions within a split second of one another" (Taylor, 2002, p. 40). Such interactions, while appearing simple, consist "of a fluid and complex stream of behaviours which are interwoven and extremely difficult to code" (Meares, 2000, p. 6). As Meares (2000, p. 6) notes, if there is a break in the patterning in these proto-conversational interchanges, "a failure of attunement is quickly perceived by the baby, whose rapidly changing expressions are surprisingly subtle". When this happens the pleasure inherent in the 'conversation' for both partners is lost. Meares (2000, p. 16) suggests that the experience could be referred to as 'disjunctional anxiety' and notes that such observations suggest "the proto-conversation is not mere to and fro. The resonance between the 'conversing partners has a transformational effect".

This contention is supported by research in the field of 'emotion regulation' which suggests that children learn to regulate their emotional responses "through specific patterns in which the matching of affective states and reparation of interactive and affective 'mismatches' . . . have fundamental importance" (Reck et al., 2004). As Reck et al. (2004, p. 274) note, "typically, early interactions . . are characterized by good attunement or synchronicity of behavioral and physiological rhythms and thus attain reciprocal optimal stimulation and arousal modulation".

During 'stressful' interactions, however, such 'optimal stimulation and arousal modulation' as Reck et al. (2004) refer to it, does not occur and the child becomes distressed. Tronick and his colleagues (Tronick, Als, Admson, Wise & Brazelton, 1978, cited in Tronick, 1998) showed how this can happen with their 'Face-to-Face Still-Face Paradigm[25]' where they instructed mothers not to engage in their normal interactive

[25] This experimental procedure was developed by Tronick et al. (1978, cited in Tronick, 1998) and consists of a mother holding a still-face and remaining unresponsive to her infant even as it tries to engage her attention.

behaviour but rather to face their infant but remain unresponsive. As Tronick (1998, p. 292) notes

> [t]he effect on the infant is dramatic. Infants almost immediately detect the change and attempt to solicit the mother's attention. Failing to elicit her response, most infants turn away only to look back at her again. This solicitation cycle may be repeated many times. But when the attempts fail, infants withdraw, lose postural control and self-comfort in response to their failure to repair the interaction.

As Tronick (1998) further notes, the disengagement is profound even with this short break in the mother-child interactions. Tronick (1998) suggests that the response of the infants is reminiscent of the withdrawal of infants in institutions such as those in Romania and highlights the absolute necessity of the mother-child interactions to a child's emotional well being.

Trevarthen and Aitken (2001, p. 9) suggest that such findings indicate the human infant has

> expectations of the emotional quality of the engagement [with their 'conversational' partner] and the normal contingencies of a sympathetic adult response, and that these emotions change in ways that affect the adult, regulating positively towards a happy encounter, and defending against failure of contact, by appealing with negative emotional expressions for appropriate remedial action to repair communication.

Trevarthen (2001, p. 851) further suggests that such research findings show "how sensitive a young infant is to affectionate parenting and they explain how failure of caregiver support is potentially harmful".

As was noted in Chapter Three, it is from within these very early, pre-linguistic, symbiotic interactions between the mother and the child, that the two aspects of our personal being which comprise 'Self 1' begin to emerge; (a) a sense of one's embodied self as the centred structure of our own perceptual field (Harré, 1998) and (b) the sense, and eventual discursive presentation, of oneself as an agent.

At the same time, these symbiotic interactions are also scaffolding and facilitating the eventual emergence of those aspects of our experience conceptualised by Harré (1998) as being part of our 'Self 2'; the "ephemeral flows of activity, both private and public, in which that person engages, producing thoughts and actions sometimes but not always displaying repeated structures and forms" (1998, p. 135). Self 2 is essentially "the totality of attributes both ephemeral and enduring of the person I am" (Harré, 1998, p. 148) and also includes beliefs about those attributes. As was noted in Chapter Three,

the 'quality' of these interactions also affect the 'value' which the child learns to associate with their sense of 'self'.

Thus, at the person level, it is suggested that if there are early relational problems of one sort or another this will interfere with the processes involved in acquiring the 'ontological skills' necessary to developing these various 'senses of self'. In other words, if the primary care-giver does not 'afford' the child the opportunity to express the various behaviours which form the foundations of the socio-emotional and practical skills and abilities essential to being a person in their world then, unless someone else steps into the breach and does so, the child will be unlikely to gain those skills and abilities. I will discuss the ways in which unsupportive parenting may compromise the emergence of the various aspects of the 'self', and thus confer vulnerability to psychological suffering, in some detail in Chapter Six.

It should be noted at this point that this is not to say that such early experiences will result in the complete absence of a 'sense of self', indeed such a complete absence would be possible only in the event of a child being raised with absolutely no human contact at all. What it does mean, however, is that early relational problems of the kind described herein will inevitably affect the emerging senses of self in ways which make life considerably more difficult, as will be discussed in some detail below. It is in this sense that I refer in this and following chapters to 'damaged' or 'compromised' senses of self.

At the organismic and neurobiological level, as already mentioned in Section 5.4.1, research suggests that the stress response systems of children whose mothers show a "high level of emotional unavailability – either as an intentional tactic or as a side effect of her own depressed state" (Bugental et al., 2003, p. 241) may be adversely affected. A study by Bugental, Martorell and Barraza (2003) for example, found that children of depressed and/or unresponsive mothers had higher baseline levels of cortisol than 'normal' controls and the authors suggest that such "elevated baseline levels of cortisol may be thought of as reflecting children's characteristic levels of HPA activity" (Bugental et al., 2003, p. 241).

Bugental et al. (2003) go on to note that the mother's 'emotional unavailability' may limit her utility as a means of buffering her child against stress – at both the neurobiological 'tool' level and the personal level. Such 'hypercortisolism' while it may be a useful short-term 'strategy' for coping with unbuffered stress, tends to be associated

at later ages with 'internalising problems' (e.g., anxiety and depression) (Bugental et al., 2003).

Bugental et al. (2003) also found that the very early use of corporal punishment heightened children's reactivity to stress. Bugental et al. (2003, p. 244) note that such hormonal reactivity may be seen as reflecting the child's "vulnerability to unexpected, challenging, or novel life events" and suggest that

> when mothers make use of physically punitive tactics at an age when children are as yet unable to regulate their behavior effectively children appear to become more susceptible to the effects of stressful events.

As was noted in Chapter Four the physiological reactions to stress shown by infants whose mothers are either 'emotionally unavailable', or who use harsh control tactics leads to maladaptive changes in stress response systems such as the HPA axis and

> may alter the functioning of the hypothalamic-pituitary-adrenal (HPA) axis in ways that, if continued, may foster risk for immune disorders, sensitization to later stress, cognitive deficits, and social-emotional problems.
>
> (Bugental et al., 2003, p. 237)

Further, research suggests that such stress sensitization would then, in turn, impact at the person level as either what psychologists would call 'emotional reactivity' (quick to cry, irritable, prone to temper tantrums) or, in some cases, 'emotional hyporeactivity' (socially withdrawn, emotionally flat, etc.). As Perry (2001, p. 8) points out, the way in which a child responds, both at the neurobiological/organismic and the personal level, to adverse experiences depends on "the nature, frequency, pattern and intensity" of the experience, "the adaptive style of the child" and the presence of mitigating factors such as the presence of a supportive person in their lives.

These 'difficult' behaviours, particularly if they were towards the reactive end of the spectrum, would then affect the mother who, if already under stress and unable to meet her child's relational needs, would be very unlikely to respond to the child's behaviour positively. If the mother did respond to her already highly 'stressed' child negatively this would, of course, be felt at every level of the child's being – molecular, organismic, and personal, as 'stressful' and aversive, and on the vicious circle would turn.

Indeed, many children from home environments characterised as risky (i.e., marked by recurrent episodes of anger or aggression and/or by interactions which are cold, unsupportive and neglectful) (Perry, 2002; Repetti et al., 2002, p. 345; Wismer Fries, 2004) have been reported to experience numerous problems which may reflect the cascade of person-level and organismic/neurobiological level factors described above (Perry, 2002; Repetti et al., 2002; Wismer Fries & Pollak, 2004). Such problems include 'developmental delays' of perceptual and motor skills as well as socio-emotional problems including hyperactivity, emotional over-reactivity and under-reactivity and social withdrawal. The ways in which such problems compound to the point where a person suffers the kinds of experiences conceptualised to be symptomatic of 'schizophrenia' or 'depression' will be discussed in Chapter Six.

Essentially, then, a socially stable and structured environment during the period of psychological symbiosis, the most important aspect of which is a stable and loving mother-child relationship, enables the child to develop, at both the neurobiological level, and at the psychological or 'personal' level, in a way which suits that child to life in his or her socio-cultural niche. Interactions within this environment essentially scaffold the emergence of the senses of 'self', as outlined by Harré (1998), which comprise our personal being and enable the emergence, within the active relationship between the child and significant others within their early environment, of 'personal' needs and desires[26] (Burkitt, 1991).

These early social interactions essentially provide a means by which children orientate themselves in the world and the foundations upon which the successful learning of language can occur. In addition, and fundamentally linked to this, a socially stable and structured environment also enables the child's neurobiological tools to develop in ways adaptive to living a life as an active and engaged member of their society.

It follows that if such a socially stable and structured environment is not available to the child then this compromises their development at the neurobiological and the personal/psychological level. If a mother consistently behaves in ways which

[26] As already noted in Chapter Three, this is not to say the child has no needs or desires before this process starts but rather that their very basic needs and desires are transformed via the interactions they have with their social world into more complex 'socially constructed' needs and desires.

interfere with the meeting of a child's basic physical and relational needs[27] the child will be put under stress (which, if prolonged, has adverse impacts on the development of the child's neurobiological tools) and also makes it less likely that they will absorb the social meanings necessary to orientate themselves within the wider social world outside the home.

Indeed, there may well be grounds to suggest that such 'disengagement' is not an uncommon occurrence within modern Western families, given the intense pressure placed on just one or two people within the isolated context of the nuclear family, to provide for all a child's socio-emotional needs during their early years, especially if there are any extra problems such as financial difficulties, work stress, family problems, illness, separation and divorce or parental 'mental illness' of any kind.

Further, if, in addition to maternal disengagement or inability to respond to the child's needs, the child also has to deal with an unstable and chaotic environment (e.g., constantly changing step-fathers, frequent shifts of house and school, violence, abuse[28], drug and alcohol abuse, or absent or grossly neglectful parents) they would, in the absence of any mitigating factors, absorb unstable and chaotic patterns of behaviour and would gear their expectations of life towards more of the same. Again this would put them under considerable stress and the strategies (e.g., hyper-vigilance, avoidance, and, in extreme cases, dissociation) they developed, at a personal level, to deal with the situations they found themselves in would be unlikely to be adaptive in the world outside of their home environment.

As has already been noted in Chapter Four, such chaotic environments also severely compromise the child's developing neurobiological tools because the developing brain requires "patterns of sensory experience to create patterns of neural activity that, in turn, play a role in guiding the various neurodevelopmental processes involved in healthy development" (Perry, 2000, p. 15). As has also been noted above, research suggests that if a child's experience of life is chaotic and the sensory inputs are not consistent or predictable then "the organizing systems in the brain reflect this chaos

[27] Such maternal 'unresponsiveness' to a child's needs may range from being chronically disengaged through to being over-attentive to the point of intrusiveness and may also include behaviours which could be referred to as 'abusive', either emotionally or physically.

[28] It is important to note that while that others within the child's environment may be abusive if the child is buffered from the stress of that abuse by the person with which s/he has the most significant relationship (usually, though not always, the child's mother) then the consequences will not be as adverse (Finkelhor, 1990). If the abuser is the person with whom the child has the most significant relationship, however, then this causes major problems – the extent of which are detailed in the literature on the neurodevelopmental and socioemotional effects of abuse (see Finkelhor, 1990 for a review). The implications of this will be discussed in more detail in Chapter Six.

and, typically, organize in ways that result in dysregulation" (Perry, 2000, p. 15). While such neurobiological organization may, in fact, be adaptive for the environment within which the child finds him/herself, as has been noted at several points, as may any personal/psychological strategies the child develops to cope with that situation, it would be unlikely to serve them well outside that environment.

5.5. CONCLUSION

Essentially, the analysis presented in this thesis suggests that if a child's basic relational needs are not met by their care-giver(s) vulnerabilities will be conferred upon the child at the molecular, the organismic and the person-level which may, in coaction with later life circumstances, result in the emergence of psychological suffering. This contention is supported by research that suggests that 'adverse' or 'unsupportive' parenting is a risk factor for the occurrence of a number of 'psychopathologies' (Beardslee et al., 1998; Downey & Coyne, 1990; Enns, Cox, & Clara, 2002; Heider et al., 2008).

At the person-level if the child's primary care-giver fails to provide the kind of care 'expected' and needed by the human child then this compromises the emergence of the skills and abilities foundational to building the 'senses of self' which comprise our personal being. At the organismic and molecular level such failures expose the child's stress response systems to chronic and unbuffered stress, stress that eventually results in 'dysregulations' of these systems and a lessened ability, at an organismic level, to respond to stressors in an adaptive way. Such 'dysregulations' also, of course, exert an effect at the person-level because such chronically dysregulated neurobiological 'tools' are less able to subserve the person-level tasks the person must perform during their lives.

While it is being argued that early relational problems of one kind or another lie at the root of most, if not all, of the various forms of psychological suffering conceptualised as 'mental disorders', this is not to say that such early relational problems will inevitably result in such suffering. No factor, not even one so fundamental as the early relationship between a child and its primary caregiver, can ever entirely determine an outcome in a dynamic system such as a human being. There are a myriad

of factors that may tip the scales in either direction – towards suffering, or towards flourishing, at this very early point in a person's lifeline.

For example, it is suggested that if the relationship between the infant and their primary care-giver is 'mended' early enough, or replaced or supplemented by another relationship(s) this may allow the child to acquire, albeit slightly later, those 'ontological skills' central to the 'senses of self' as outlined by Harré (1998). In addition, the now positive interactions between the child and his or her care-giver would be very likely to transform the valency of their early 'feeling tone' from negative to positive. This in turn may have the potential to initiate a reassessment of the value they have assigned to their 'self' – from negative to positive.

Indeed, all through a person's childhood, no matter how adverse it may seem to be, there may arise situations with the potential for conferring resilience as well as vulnerability (Masten & Obradovic, 2006). There may be, for example, a supportive aunt or grandmother who acts as a buffer against the stress of the mother-child relationship and any other chaos that might prevail in the child's home and provides the child with opportunities to build the skills and abilities required for a relatively stable, coherent and valued sense of self. Or there may be a teacher who takes a special interest in the child, thus enabling them to begin to realise their capacities for learning and for achievement, which in turn may precipitate a reassessment of the value they assign to their 'self'. Thus it may be that while the child will always carry with them the 'scars' (literally and metaphorically) of early relational problems, they may live out their life without ever experiencing the kind of suffering which would bring them to the attention of the mental health profession.

It is contended, however, that early relational problems of the kind described in this thesis will make people more *vulnerable* to the effects of stressors and/or loss of or lack of social support, and the earlier and the longer a person is exposed to such problems the more vulnerable they will be. As they move through childhood and adolescence and into adulthood these people, if subjected to enough 'stress', will break down sooner and suffer more intensely, than people who are not as vulnerable and their suffering will be much more likely to be formally diagnosed as a 'mental illness' of one kind or another.

What is felt to be 'stressful' and what is not, is bound up in the feelings, and the meanings, people have learned to associate with certain events. As has been noted above, such feelings arise out of our reactions to what happens to us over the course of

our development. As was discussed in Section 5.4.1, while a person may not 'remember' such feelings, or the experiences that gave rise to them, in such a way as to enable them to narratively reconstruct them, these feelings and experiences will nevertheless exert an ongoing effect. These embodied feelings are there from the very beginning, long before we develop an overt facility with language, and they remain at the core of our experience throughout our lives (Cromby, 2006b).

Because the early life of those who have received inadequate care of one kind or another have been, at a person-level and an organismic/molecular-level, highly stressful, as has been outlined above, many of the 'embodied feelings' of such people are essentially of a negative nature. As a number of theorists from both the biological and social sciences have noted (Meares, 2000; Perry, 2002; Schwarz & Perry, 1994) such feelings can then be 'triggered' or 'called out' by subsequent events in a person's life which 'remind' them of the original event(s). Thus, relatively minor relational 'failures' – a certain 'look' from a loved one, getting turned down for a promotion, a friend's perceived slight – may 'trigger' or 'call out' highly negative embodied 'memories' of separation and abandonment which then precipitate feelings and behaviours which, to onlookers, may seem to be out of all proportion to the event.

At the organismic/molecular level the reactivation of such 'memories' would initiate the body's stress response systems (Schwarz, 1994), already sensitized due to stress-induced vulnerability of limbic areas (Post, 1992; Post, Weiss & Leverich, 1994, cited in Harkness & Tucker, 2000) resulting in either hypo- or hyper-arousal (Perry, 2001, p. 5).

At the person-level such 'memories' would be experienced as intensely negative feelings (e.g., fear, anger, panic, hopelessness) accompanied by disturbing thoughts and bodily sensations over which the person would feel little control (Schwarz, 1994). Further, such feelings may then stimulate behaviour that may seem 'hyperactive' or 'over-the-top', or, conversely, behaviour that is suggestive of hesitance, avoidance or numbness (Garmezy, 1974; Schwarz & Perry, 1994). Perry (1991) suggests that such 'malignant memories' (Schwarz & Perry, 1994) are the basis for the characteristic symptoms of post-traumatic-stress-syndrome (PTSD) and may also underlie, or contribute towards, a number of other so-called 'psychopathologies'.

Because of this, people with who have experienced the kind of 'unsupportive parenting' experiences and adverse home environments discussed above are not only more vulnerable to the effects of stressful events they are also likely to find *more* events

stressful due to the the effects wrought by the reactivation of such embodied memories from their early lives. Thus, in the manner of all dynamic systems the occurrence of certain events during the course of a person's lifeline may, due to their timing, their intensity and/or the meanings they carry for the person involved, eventually result in the kinds of experiences which are conceptualised as being due to a 'mental disorder'/'dysfunctioning mind'. I will discuss in more detail how early vulnerabilities may, depending on the complexities of each person's lifeline, result in the experiences involved in two of psychiatry's major 'mental disorders' – 'schizophrenia' and 'depression' – in Chapter Six.

CHAPTER SIX

APPLYING THE PERSON-BASED ACCOUNT TO 'SCHIZOPHRENIA' AND 'DEPRESSION'

6.1. WAYS OF BEING, WAYS OF SUFFERING

Pain is in my neck. Sorrow is in my head and neck. Anguish is in my shoulders. All suffering is truly in me.

Anonymous (Bouricius, 1989)

I spent day after day crying, huddled up in bed where I felt safe and could do no harm to myself. I could not concentrate to read or even watch television, and I did nothing for hours on end. My appetite disappeared, and I was constantly exhausted.

Kathryn (McNeil, 1993)

An indescribable anguish squeezed my heart , an anguish no resolve could allay. If I refused to obey, I felt guilty and cowardly for not daring, and the anguish mounted. Then the order became more insistent. If, finally to obey, I went to the fire and stretched out my hand, an intense feeling of guilt overcame me as though I were doing something wicked, and the anxiety waxed in proportion. I should say, however, that the latter alternative provoked a greater disturbance, for I felt that if I obeyed the order, I should commit an act irreparably damaging to my personality.

Marguerite (Sechehaye, 1964)

The mornings themselves were becoming bad now as I wandered about lethargic . . . but afternoons were still the worst, when I'd feel the horror, like some poisonous fogbank, roll in upon my mind, forcing me into bed. There I would lie for as long as six hours, stuporous and virtually paralyzed, gazing at the ceiling and waiting for that moment of evening when, mysteriously, the crucifixion would ease up just enough to allow me to force down some food and then, like an automaton, seek an hour or two of sleep again.

William (Styron, 1990)

Voices, like the roar of a crowd came. I felt like Jesus; I was being crucified. It was dark. I just continued to huddle under the blanket, feeling weak, laid bare and defenceless in a cruel world I could no longer understand.

Stuart (Myers, 2001)

The above quotations are from people who have been diagnosed with one or other of the two 'mental disorders' that will be the focus of the analysis presented in this chapter. What is most apparent reading through even such brief excerpts as these is that central to the experience of such 'disorders' is intense suffering. These people experience emotional and physical pain, deep sorrow, fear, exhaustion, weakness, and vulnerability. They feel confused, trapped, out of control and out of touch with the world. They feel hopeless, numb, self-destructive and overwhelmed. They use words and phrases such as 'chaos', 'dark', 'black poisonous fogbank', 'crucifixion', 'treacherous quagmire' and 'abyss' in order to convey something of the anguish they experience in order that we, who have not felt these things, might understand what it is like to be them.

As was pointed out in Chapter Two the experience and the genesis and maintenance of such suffering is still essentially mystifying to those who approach it as the result of a 'dysfunctioning' mind (or brain) because the assumptions about human beings which underlie this view are inherently faulty. If we take the view of human beings espoused in this thesis, however – that individual experience does not arise from 'within' the individual but rather is socio-culturally and biologically co-constituted over the course of one's lifeline – such experiences become more 'understandable[1]'

The analysis sketched out in Chapter Five suggested that the kinds of suffering exemplified by the two disorders which will be the focus of this chapter should not be conceptualized as 'illness' or 'dysfunction' but, rather, as experiences and 'ways of being' that emerge from the complex coactions between the biological, the personal and the social aspects of our lives. It was essentially argued that our personal being and the neurobiological tools that subserve that personal being, develop within the context of the psychologically and biologically symbiotic interactions occurring between a child and significant others in their environment, usually, in the modern Western context, the mother. Because of this, it was suggested, problems within this relationship can exert potentially profound effects at the organismic, molecular and the personal level, effects that confer upon the child vulnerabilities to the kinds of suffering conceptualised as 'mental disorder'.

[1] As has already been noted in Chapter Two (see Footnote 25), Karl Jaspers, a German psychiatrist who initiated the phenomenological movement in psychiatry noted in his *General Psychopathology* (1913, 1963, cited in Sass, 2002) that some 'mental disorders' are 'understandable' and some are 'un-understandable' – closed to psychological comprehension or understanding.

What makes the difference between how such generalised vulnerabilities may 'play out' as particular kinds of suffering, however, is to be found in the complex coactions between these organismic, molecular and person-level vulnerabilities conferred by such unsupportive and/or abusive parenting and the ongoing events of each individual life. Out of such coactions, it is suggested, emerge a 'cluster of sufferings' unique to each person. That these 'sufferings' tend to cluster together and seem, because of this, to suggest underlying 'pathologies' representative of various discrete 'disorders' or 'illnesses', simply reflects the reality that many people have very similar experiences. These experiences, due to us all being animals of a particular kind who require particular environmental contingencies in order to flourish, play out in broadly similar ways, though they can never, of course, be exactly the same.

In light of this observation it was decided that rather than approaching the task of understanding such sufferings by looking at individual 'symptoms', which is an approach commonly taken by those critical of the 'disorder' based approach to psychological suffering, I would acknowledge the reality that such sufferings do indeed cluster together and look at two of psychiatry's major 'clusters' – conceptualised as 'schizophrenia' and 'major depressive disorder'.

This does not mean, however, that I am endorsing the view that 'schizophrenia' and 'major depression', or any of the other 'mental disorders' for that matter, are discrete 'disorders' or 'illnesses' which occur due to underlying 'pathologies' of the 'mind' or brain and which are easily distinguished from each other.[2] Indeed, as has already been discussed in Chapter Two, this is a highly contested notion, and one that lacks strong theoretical or empirical support.

This also means that the analysis below is, necessarily, a general one that will apply to some people who have been diagnosed as 'schizophrenic' or 'depressive', but may not apply to others. Thus, the purpose of the analyses presented below is simply to illustrate, by way of example, that there may be alternative routes to understanding the genesis of the cluster of sufferings conceptualised as 'schizophrenia' and 'depression'.

While there is an emerging consensus that such 'clusters of suffering' emerge out of the complex coactions between organismic, molecular and person-level factors, particularly amongst those working in the field of 'developmental psychopathology' (e.g., Cicchetti, 1996; Sroufe & Rutter, 1984; Steinberg & Avenevoli, 2000), the vast

[2] It should be noted at this point that in order to avoid ponderous phrasing I may, at times, utilise these diagnostic terms in ways that may seem to the reader to reify them. This is in no way the intention and it is hoped that when such apparent reifications occur they will be understood as linguistic conveniences.

majority of theorists, including most developmental psychopathologists, still tend to give priority to organismic and molecular level factors in the genesis of such suffering. While such organismic and molecular level factors may precipitate and exacerbate psychological suffering it is suggested that it is person level factors, particularly those which occur within, and emerge out of, our interactions with our primary care-giver, which give particular shape to these 'sufferings' due to their effects on the early stages of the emergence of the various 'senses of self' (as outlined in Chapter Three) which comprise our personal being.

It must be stressed, however, that this focus on person-level factors in no way negates the centrality of the organismic and molecular level factors in the genesis and experience of psychological suffering. As I will attempt to sketch out below, the emergence of such suffering depends on coactions between these factors, all of which are necessary for the emergence of psychological suffering but *none* of which are sufficient to it. What *is* being argued, however, is that it is to person-level factors that one must look to understand the genesis of the *particularities* involved in the various 'clusters of suffering' conceptualised as 'mental disorders'. Indeed, given the profoundly personal nature of psychological suffering, the subjective experience of which is 'located' at the person level and talked about using P-grammar[3], there is really no other place to look for such understandings.

Indeed, it is because of this that I will not, as has already been noted in Chapter Five, be speculating about the role various genes may play in the genesis of 'schizophrenia' or 'depression'. While it is acknowledged that it is *possible*, although this has by no means been proven beyond a doubt, that certain genetic profiles may make a person more vulnerable to suffering psychologically in certain environments the position being taken here is that it is the environment within which those genes are expressed, and within which a person lives out his or her life, that makes the difference between a person experiencing suffering or not experiencing suffering. The same point applies *vis a vis* various other biological factors which have been the subject of much speculation from researchers attempting to find the 'causes' of 'mental illness' – for example, viruses, birth defects, birth trauma, etc..

Indeed, as Read, Perry, Moskowitz and Connolly (2001) note, one of the rare studies to evaluate the families who have adopted the 'at-risk' offspring of parents with 'schizophrenia' found that only 4% of those children raised by 'healthy' adoptive

[3] See Chapter Five for a discussion of the different 'grammars' which need to be utilised when discussing different aspects of our being in the world.

families were diagnosed as 'severe and psychotic' compared to 34% of the children raised by 'disturbed' adoptive families. Tiernari et al. (1991, p. 463, cited in Read et al., 2001, p. 325) concluded that "in healthy rearing families the adoptees have little serious mental illness, whether or not their biological mothers were schizophrenic". Thus, notes Read (Read et al., 2001, p. 325), "dysfunction of the family, and the maltreatment of the child implied thereby had 7 times more explanatory power than genetic predisposition".

Similarly, a study which found that a polymorphism in the 5-HTT gene occurs more frequently in those who are depressed (although it should be noted that this is not a consistently replicated finding[4]) also found that people with this gene only get depressed if they are exposed to multiple stressful life events (Capsi, Sugden, Moffitt, Taylor et al., 2003). Further, not all people who are depressed have this polymorphism. Claiming, as a number of media reports have done, that such research has discovered the 'gene for depression' is, quite simply, wrong. Indeed, it is akin to suggesting that having two X chromosomes is involved in the genesis of depression because this chromosomal pattern is found more frequently in people who are depressed.[5]

Thus the focus of this analysis will not be upon a person's genetic make-up, or on any other biological 'vulnerabilities' which *may* increase a person's likelihood of suffering psychologically, *within a certain environment*, rather it will be upon the processes that do, and do not, occur within their social environment, and the possible effects of these on the development of a person's neurobiological tools and their emerging personal being.

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6.2. SCHIZOPHRENIA

> He tended to lose the sense of whose thoughts originated in whom, and felt 'as if' his interlocutor somehow 'invaded him', an experience that shattered his identity and was intensely anxiety provoking. When walking on the street, he scrupulously avoided glancing at his mirror image in the windowpanes of shops, because he felt uncertain on which side he actually was.
>
> (Parnas & Handest, 2003, pp. 129-130)

[4] See, for example, a review by Thapar, Harold, Rice, Langley & O'Donovan (2007).
[5] As Gotlib and Hammen (1992, p. 18) note, "considerable evidence across a wide array of methods of investigation suggests that women are about two times more likely to experience clinical depressions than men".

> . . . I wonder if I ever knew myself, or merely played the parts that were acceptable, just so that I could fit in somewhere.
>
> Mary (M. E. McGrath, 1984, p. 838)

> Early on, I was aware that something was terribly wrong with me, that something was 'odd within', though I never could have put a name to it or expressed the experience in words.
>
> (Wagner, 1996, p. 400)

> I am a lonely nothing, a being, but pass me by. Forever pass me by. Strangers, I don't see you. My afflictions fill the place that was meant for sharing love. I am crying in despair.
>
> Anonymous (Bouricius, 1989, p. 202)

The latest version of the Diagnostic and Statistic Manual, the DSM-IV-TR (American Psychiatric Association, 2000) suggests that to be diagnosed as 'schizophrenic' three diagnostic criteria must be met. These are:

(1) Characteristic symptoms such as delusions, hallucinations, disorganized speech, grossly disorganized behaviour (often characterised as 'positive symptoms'), negative symptoms – affective flattening (loss or decline in emotional response), alogia (slowed speech), or avolition (lowered motivational levels);

(2) Social/occupational dysfunction: Work, interpersonal relationships or self-care must be markedly affected for a significant amount of time since the onset of the disturbance;

(3) Duration: The disturbances must have been experienced for at least six months.

The seemingly straight-forward nature of this list of criteria belies, however, the wide range of experiences which are conceptualised as 'schizophrenia'. As MacDonald and Schulz (2009, p. 495) point out in an article attempting to summarise the known 'facts' about 'schizophrenia', "schizophrenia has a heterogeneous presentation, with disorganized, positive, and negative symptoms having different levels of prominence

across time and across individuals". Indeed, as was noted in Chapter Two, 'schizophrenia' has been singled out for particularly intensive criticism even in comparison to other so-called 'mental disorders', for its "weak diagnostic accuracy, uncertain aetiology and dustbin-like character" (Miller, 1986, p23).

In an ongoing exploration of 'anomalies of subjective experience' in schizophrenia Parnas and his colleagues (Parnas & Handest, 2003) (Parnas, Handest, Jansson, & Saebye, 2005) (Parnas & Sass, 2002) (Sass, 2002) suggest that what characterises the 'schizophrenic' experience more than anything else is "certain alterations in the *structure* of consciousness", alterations which not only generate 'strange experiences' but also "altered *forms* of subjectivity" (Cermolacce et al., 2007, p. 705, authors' italics). These authors suggest that particularly prominent among these 'anomalies' are 'disturbances of self'.

Indeed, ever since its 'discovery' in the nineteenth century schizophrenia has been characterised as "a brain disorder that is manifested as a disturbance of self" (Keefe & David, 1998) with Lysaker and Lysaker (2002) noting that "there has been almost uniform acceptance that a disruption in sense of self is a universal experience among persons with schizophrenia". As Davidson and Strauss (1992) note, however,

> while a distortion of self remains to this day an essential phenomenological characteristic of schizophrenia . . . it has received considerably less attention in recent years with the increasing support for 'descriptive' and biological approaches to severe mental illness.

According to Cermolacce et al. (2007) the most prominent feature of the 'disturbances of self' involved in schizophrenia is essentially something Blankenburg (1971, cited in Cermolacce et al., 2007, p. 706) called a "'loss of natural self-evidence', a deficient pre-given obviousness and naturalness of the world and people". Cermolacce et al. (2007, p. 706), in presenting a case study to illustrate this, note that their patient, Maria, "experiences a constant lack of immersion in the environing world, an impossibility of full presence". Maria complains that due to an invisible barrier preventing her full presence, she is never able to be fully spontaneous and immerse herself in the world. She feels as if she is "living life in a fog" and notes that at times she feels as if she is only "seventy percent conscious".

While Maria acknowledges ownership of her thoughts she experiences them at a distance, as if they do not come from her own self. She feels as if she is not fully alive, she is not "quite human" or "from this planet", as if, suggest Cermolacce et al. (2007, p. 706) "she were a thing, a physical object, rather than a subject". Cermolacce et al. (2007)

go on to note that such feelings may seem quite trivial or ordinary but on closer examination they seem to "be related to a disturbed ability to grasp every day significations of the world". For Maria, these feelings

> appear as motivated by a profoundly disturbed, *incomplete sense of instantaneous self-identity* which she first experienced in her early childhood. She was always insecure of herself, "*lacking a solid attitude*". Now, she has a difficulty in interacting with others; she does not know what to say and what to mean. Looking at her own hands may surprise her and she may stare in the mirror, sometimes for hours, inspecting her facial appearance.
>
> (Cermolacce et al., 2007, p. 706, authors' italics)

According to Cermolacce et al. (2007, p. 706), Maria's "clinical picture is a typical example of premorbid experience and behaviour of schizophrenia". They suggest that such thoughts and feelings are due to "a sense of personal insecurity (often associated with a feeling of being profoundly different from others) and a lack of 'common sense' – a term which they use to refer to a "tacit, fluid, context-sensitive and automatic pre-understanding of and attunement to other people and situations" (Cermolacce et al., 2007, p. 706).

Cermolacce et al. (1997, p. 706) note that the changes of awareness experienced in the early 'prodromal' stages of schizophrenia comprise "a family of complaints about a certain unclarity or opacity of *consciousness* and a diminished sense of inner aliveness" (Cermolacce et al., 2007, p. 706, authors' italics) that are very difficult for the person to put into words and "even more difficult for the psychiatrist to enquire about". Such experiences, they suggest, indicate "a very fundamental disturbance of the self in schizophrenic conditions"; a disturbance, essentially, of the first person perspective which for most people is "an experience given to me as *immediately mine*" (Cermolacce et al., 2007, p. 706, authors' italics).

The sense of self which Cermolacce et al. (2007) suggest is disturbed in schizophrenia is essentially the first aspect of 'Self 1', as described by Harré (1998, p. 4); the

> sense of one's location as a person, in each of several arrays of other beings, relevant to personhood . . . the sense of one's point of view . . . a location in space from which one perceives and acts upon the world, including the part that lies within one's own skin.

This sense of self, as Cermolacce et al. (2007, p. 707, authors' italics) go on to note, does not belong to someone

> in the sense of a relation . . . of ownership, but rather as *an identity* of experience, as *being me* in an un-mediated way, without a gap or a fissure between the experience and the sense of self. The first person perspective is a *way* or a *form* in which the experience manifests itself and is self-aware. This mode of self-articulation of self-awareness of experience is called 'mineness' or *ipseity*.

Central to this sense of self is the reality of our biophysical embodiment. In line with Harré's (1998) analysis, Parnas and Handest (2003, p. 126) note that "conscious experience is . . . never purely cognitive or spiritual but is closely intertwined with our bodily existence and experience". Because we are physically embodied creatures "embodiment is a fundamental condition of selfhood". As Parnas and Handest (2003) further note,

> The body has ambiguous experiential status: at the one extreme it is a 'lived body' . . . , i.e., subjective, animated body, identical with the self; at the other extreme it is experienced as a physical, spatially extended object or thing . . . Incessant oscillation or interplay between these experiential bodily modes constitute a tacit foundation of all experiencing.

As was noted in Chapter Three, while our sense of experiencing ourselves as an embodied perceiver in the world, and of seeing everything from that viewpoint, is the most basic aspect of consciousness it is, nevertheless, not something which occurs solely within the person. Consciousness, it was suggested, is relational, which makes our ability to perceive an active process at every level. And because it is an active process it requires action and, inevitably, interaction with other 'things' in the world, material and, most importantly, social.

Thus, in line with the position held by Harré (1998) and Shotter (1984; 1993a), Cermolacce et al. (2007, p. 705) describe such a sense of self as

> a mutally constitutive relation between the organism and its Um-welt, the latter composed of 'domains of significance' or affordances. In other words, the lived world, - as it is patterned by and is patterning my first person perspective, always contains a ubiquitously implicit sense of unique familiarity, and thus exerting a stabilizing influence on the very structure of my (first-person) experience of the world.

Also in line with Harré (1998) and Shotter (1984, 1993), Cermolacce et al. (2007, p. 705) suggest that because of this

> one should not think of the first person perspective in a strictly internalistic manner as an immanent formal cognitive structure, 'void of personality', as an attention-ray from an abstract disengaged ego-pole. If the organism were not motivationally geared to its encounter with the world or if the subject was not a being in the world, there would be no articulation of such affordances.

As has also already been noted in Chapter Three, Harré (1998, p. 104) suggests that the origins of this sense of 'self' "lie in the manipulative practices with which . . . an infant begins to appreciate its world as ordered, with respect to its own position as an embodied being among other things and beings of that or similar sorts". Because of the initial helplessness of the human infant such manipulations must, as was discussed in Chapters Three and Five, be scaffolded and thus enabled by other human beings in the child's world. In Western contexts it is mainly the child's mother who fulfils this role during early infancy. It is, suggests Shotter (1974a) via such enablings that children learn to coordinate their actions with their perceptions, thus allowing them to gradually incorporate the structure of their environment into their actions so that they learn to meet their environment with the right response.

Given this analysis it is possible that while most attempts to understand the schizophrenic experience blame such disturbances of self on 'dysfunctioning' neurobiology, such disturbances may arise, at least in part, because of disruptions during early infancy in the processes involved in acquiring that basic sense of 'mineness' or ipseity central to the experience of being a 'self' in the world, the sense of self which enables a feeling of "pre-given obviousness and naturalness of the world and people" (Cermolacce et al., 2007, p. 706) .

Such disruptions may occur if the child is in a relationship with their primary care-giver which does not provide the kind of 'enablings' referred to above. That is not, of course, to say that the neurobiological tools which subserve the skills and abilities required to develop this sense of self do not also play a role, indeed, as will be shown in the analysis to follow, it is the coactions which occur between a person's neurobiology, their person-level reactions to the events occurring in their lives, and their disrupted or incomplete senses of self which eventually result in the experience of 'schizophrenia'.

The kind of relationship which did not provide such basic 'enablings' would, it is speculated, be marked by a high level of disengagement on the part of the primary care-giver, with any interactions that did occur being primarily of a negative nature – ranging from emotional coldness and dismissiveness through to cruelty and physical and/or sexual abuse. It must be stressed at this point that such disengagement may occur in the context of so-called 'good' homes although it will, as was outlined in Chapter Five, be much more likely to occur in 'disadvantaged' homes, as reflected in the epidemiological studies showing higher rates of 'schizophrenia' among certain socially disadvantaged groups (J. McGrath, Saha, Chant, & Welham, 2008; Reininghaus et al., 2008; Warner, 1985).

In support of the contention that certain kinds of early relational problems may be foundational for the experiences conceptualised as 'schizophrenia' a study of over 500 child guidance clinic attenders found that over 35% of those diagnosed 'schizophrenic' as adults had been removed from home because of neglect; double the rate of any other diagnosis (Robins, 1996, cited in Read, van Os, Morrison, & Ross, 2005). And a study by Cannon, Caspi and Moffit (2002, cited in Read et al., 2005) EN102), involving over 1000 people, found that those whose interactions with their mothers at age three years were characterized by 'harshness towards the child' and 'no effort to help the child' were, as adults, significantly more likely to be diagnosed with schizophreniform disorder [6]. Further, in a sample of adults diagnosed with schizophrenia 85 percent had suffered some form of childhood abuse or neglect, with 50 percent having suffered childhood sexual abuse (Howlowka, King, Saheb et al., 2003, cited in Read et al., 2005).

Indeed, a number of researchers are suggesting that childhood sexual abuse is particularly common in the early lives of people who are later diagnosed with 'schizophrenia' (see Read et al., 2001 for a review). A study by Friedman, Smith & Fogel (2002, cited in Read et al., 2005), for example, found that among a group of female outpatients who were diagnosed as 'schizophrenic' 78 percent had been sexually abused during their childhood, compared to 26 percent of people with 'panic disorder', 30 percent of those with 'anxiety disorders' and 42 percent of those with 'major depression'.

Child abuse has been linked, in particular, to the development of the 'symptoms' characteristic of psychosis (Janssen et al., 2004; Morrison, Frame, & Larkin, 2003). A study by Ross, Anderson and Clark (1994, cited in Morrison et al., 2003) found, for example, that patients who reported being sexually abused during their childhood were more likely to report psychotic symptoms that patients who did not report being sexually abused. This links with research indicating that experiencing trauma of any kind is linked to a higher likelihood of becoming psychotic (Grimby, 1993, cited in Morrison et al., 2003; Spauwen, Krabbendam, Lieb, Wittchen, & van Os, 2006). Whitfield, Dube, Felitti and Anda (Whitfield, Dube, Felitti, & Anda, 2005, p. 797) also found that there was a "statistically significant and graded relationship between histories of childhood trauma and histories of hallucinations that was independent of a

[6] The 'symptoms' of 'Schizophreniform disorder' are very similar to 'schizophrenia' but the total duration of the illness is shorter (at least one month but less than six months, whereas schizophrenia is at least six months) and impaired social or occupational functioning is not a requirement though it may occur. About half of those diagnosed with 'schizophreniform disorder' are later diagnosed with schizophrenia (Strakowski, 1994)

history of substance abuse". Hallucinations are, of course, one of the central components of the psychotic experience.

While research suggests that the incidence of childhood sexual abuse is particularly high amongst those diagnosed with 'schizophrenia', however, it is also a feature of the early lives of many of those diagnosed with various kinds of 'mental disorder' – for example, childhood sexual abuse is prevalent amongst those diagnosed with 'panic disorder', 'anxiety disorder', 'bi-polar disorder', 'major depression' and 'borderline personality disorder' (Beitchman et al., 1992; Leverich, Perez, Luckenbaugh, & Post, 2002; Read, 1997; Weaver & Clum, 1993). It is also the case that many people experience childhood sexual abuse without developing the 'symptoms' of any major 'mental disorder' (Finkelhor, 1990; Kendall-Tackett, Williams, & Finkelhor, 1993), although this does not, of course, necessarily mean that such people do not suffer from having been abused in this way (Finkelhor, 1990).

As a number of authors (e.g., Alexander, 1992; Molnar, Buka, & Kessler, 2001) point out, childhood sexual abuse usually occurs as part of a general cluster of family adversities, including factors such as 'maternal unavailability', 'absence of a biological parent' and a 'poor relationship' with parents (Alexander, 1992), all factors which may result in the basic 'disturbances of self' suggested to underlie 'schizophrenia'. Peters (1988, cited in Alexander, 1992) found that maternal warmth emerged as a stronger predictor of adjustment in adulthood than did abuse variables (duration and severity of abuse) and Alexander (1992, p. 185) cites a number of studies showing that the severity of the long-term effects of childhood sexual abuse "appears to be mediated by the support received from the non-abusive parent".

Such findings suggest that childhood sexual abuse, in and of itself, may not necessarily be foundational of the schizophrenic experience, though having experienced such abuse would, in the light of the analysis being presented in this thesis, be expected to exert an impact on the way in which 'schizophrenia' would be experienced. If childhood sexual abuse occurs within the context of an extremely disengaged and emotionally cold child-care-giver relationship this relationship will be unable to buffer the already damaged child against the further stress caused by the abuse, thus increasing the probability that the abuse will cause even more 'damage' to the child at every level – organismic, molecular and personal – thus being more likely, particularly in the face of any intensification of the psychosocial demands placed on them, to precipitate the symptoms characteristic of psychosis. I will discuss the implications of this in more detail below.

I will now attempt to outline how damage to this basic sense of 'self' may impact on all other aspects of a person's being in the world and may lead to the constellation of 'signs' and 'symptoms' which are considered representative of the 'disorder' conceptualised as 'schizophrenia'. As Parnas and Handest (2003, p. 126) note, a disturbance of this most basic sense of self exerts

> profound reverberations on the sense of personal identity: unstable ipseity and lack of common sense[7] create a vacuum at the very core of one's subjectivity. This vacuum deprives the patient of reliable dispositional attitudes that normally imbibe cognition and emotion with a sense of typicality and familiar direction.

Parnas and Handest (2003, p. 126) suggest that such 'disturbances of presence' seem to "constitute a foundation of the more explicit and articulated anomalies of selfhood" such as a sense of identity over time or demarcation from other people (both aspects of Self 2). As Parnas and Handest (2003, p. 126) point out

> if a memory of a past event is to contribute to my sense of identity over time, it can only do this job in so far as the past event is being remembered as having taken place in my field of awareness, as something which was originally experienced from my first-person perspective.

This contention is supported by a number of studies which strongly suggest that autobiographical memory, a central 'ontological skill' involved in creating and maintaining a sense of oneself as a continuous unity through time, is disturbed in 'schizophrenia' (Danion et al., 2005; Riutort, Cuervo, & Danion, 2003) with patients recalling very few specific autobiographical memories (Riutort, Cuervo, Danion, Peretti & Salamé, 2003, cited in Danion et al., 2005).

Interestingly, it has been found that people who experienced 'emotional trauma' during their early childhood have longer periods of infantile amnesia than those who have not experienced such trauma (childhood amnesia has its offset at around 3.5 years for the general population and 6.1 years for those with a history of early trauma) (R. Joseph, 2003). Given the dearth of autobiographical memories in people who are diagnosed as 'schizophrenic', such findings provide further support for the contention being made in this thesis that early relational problems may be involved in the genesis of the experiences conceptualised as 'schizophrenic'.

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[7] As in the sense of 'sensus communis' (Gadamer, 1989, cited in Cermolacce et al., p. 706) – a "tacit fluid, context-sensitive and automatic pre-understanding of an attunement to other people and situations, the latter being constantly remodelled by our own acting". This is essentially what Shotter (1993) means when he refers to 'knowing of the third kind' (see Chapter Three, Section 3.3).

Parnas and Handest (2003, p. 126) further note that such basic identity disturbances are different from those seen in the 'non-schizophrenia spectrum personality disorders' such as 'borderline personality disorder' or 'narcissistic personality disorder'. In these 'disorders', suggest Parnas and Handest (2003, p. 126) "the identity disorder operates on the level of social self (self-image), with the sense of ipseity and pre-reflective immersion remaining intact". It is suggested in Section 6.3 below that this is also the case with 'depression'.

As Parnas and Sass (2002, p. 111) point out, "pre-schizophrenics and schizotypal patients frequently manifest behavioral abnormalities in early infancy and childhood" which may be associated with the basic disturbance of self these authors suggest underlie the schizophrenic experience. For example, research suggests children who later become 'schizophrenic' exhibit perceptual, cognitive and motor 'abnormalities' and delayed development of motor skills, especially walking, during the first two years of their life (e.g., Walker & Lewine, 1990). Socially, children who later become schizophrenic also seem to find it much more difficult interacting with other people than 'normal' controls, for example, a study by Jones et al. (1994, cited in D. A. Lewis & Levitt, 2002) observed that at age 4 years such children were observed to be more likely to play alone.

While such 'abnormalities' are often suggested to be purely due to 'dysfunctioning' neurobiology, it is possible that they may also be due, at least in part, to a constant sense of 'unmineness' of experience which by destabilising the very structure of their (first-person) experience of the world compromises their attempts to negotiate their way around that world both physically and socially.

The kind of 'abnormalities' outlined above may also impact adversely on already problematic relations between the child and their primary care-giver potentially leading the care-giver to be even more unresponsive or abusive and less able to interact with the child in ways conducive to scaffolding the emergence of the other 'senses of self' central to personal being. In addition, as already noted above, the emergence of these other 'senses of self' would already be compromised by the basic instability of the first aspect of Self 1, the basic sense of the 'mineness' of experience.

The compounding difficulties outlined above will then have repercussions for the person as they move beyond infancy and into childhood leaving them less equipped to deal with the new and increasingly challenging socio-emotional and cognitive demands of formal education. Indeed there are a number of studies which report that

children who later become schizophrenic experience numerous problems during this stage of childhood which may reflect the cascade of person-level and organismic/ neurobiological level factors suggested to contribute towards the eventual emergence of the cluster of experiences conceptualised as 'schizophrenia'.

For example, Cannon, Walsh, Hollis, Kargin and Taylor et al. (2001, p. 424) found that children who later become schizophrenic were 'abnormally suspicious and sensitive' and showed difficulty in relating to other people. Done, Crow, Johnstone & Sacker (1994) also noted children who later developed 'schizophrenia' were rated by their teachers as being more socially 'maladjusted' than controls. Reflecting the underlying physiological-level 'hyper' and 'hypoactivity' described above, even at the age of seven pre-schizophrenic boys were more likely to be rated as over-reactive than controls and tended to be described as being 'anxious for acceptance' and also as 'hostile' to other children and to adults.

When assessed again at 11 years boys showed a similar 'over-reactive' behaviour profile. Pre-schizophrenic girls were also judged to be more socially 'maladjusted' than 'normal' controls, but while the girls were rated as 'over-reactive' at age seven (though not as over-reactive as boys), by age 11 they were rated as under-reactive, being seen as withdrawn, unforthcoming and depressed. This divergence between the genders is in line with the consistent finding reported in the depression research literature that upon entering adolescence the sex difference patterns that typify adult depression begin to emerge. As Gotlib and Hammen (1992, p. 40, authors' italics) note "while studies of *preadolescent* samples typically find either no sex differences or elevations in boys' rates of depression, teenage girls are diagnosed and report symptoms of depression two or three times the rate of boys".

It is suggested that such difficulties negotiating their way around the social world may be due, in part, to the lack of "natural self-evidence", the deficient sense of the "pre-given obviousness and naturalness of the world and people" arising from fundamental difficulties with their basic sense of being in the world. As Cermolacce et al. (2007) note, such a "sentiment of perplexity" leads to excessive ruminations on everyday matters that would not concern 'normal' people, thus interfering with "normal interactions with the world". Such perplexity would be exacerbated by the impact of these early disturbances on the acquisition of the other 'senses of self' outlined by Harre (1998) – the sense of oneself as an agent in the world, and the sense of oneself as a unique human being with one's own attributes and a past, present and future which can be narrated both to the self and others.

Indeed, research suggests that people who are eventually diagnosed as 'schizophrenic' may experience 'disturbances of self' from very early in their lives. For example, "one follow-back study using objective information . . . [revealed] fluidity of self-demarcation, lack of a coherent narrative-historical self-identity, and other self-disturbances to be prominent features of the pre-schizophrenic states at school age" (Hartman, Millofsky, Vaillant et al., 1984, cited in Parnas & Handest, 2003, p. ??).

Parnas and Handest (2003) also cite the work carried out by Huber, Klosterkotter and their colleagues (Gross, Kluber, Klosterkötter et al., cited in Parnas & Handest, 2003) in Germany which have "identified subtle (nonpsychotic) affective, cognitive, perceptual, motor, and bodily disturbances" which they suggest may precede the onset of schizophrenia. As Parnas and Handest (2003, p. 123) note, "several of these disturbances reflect anomalies in self experience (e.g., varieties of depersonalization, disturbances of consciousness and action, distorted bodily experiences)".

This suggests that people who eventually become 'schizophrenic' may never feel completely 'present' in the world, they may always, in other words, feel a lack of "the sense of 'mineness' of experience" (Parnas & Handest, 2003, p. 125) central to the first aspect of 'Self 1'. Indeed Cermolacce et al. (2007, p. 705) point out that such feelings of oddness "typically arise [a] long time before the onset of the first psychotic phase of the illness" with many sufferers noting that they have felt such perplexity and 'disturbances of self' since early childhood.

For example, Parnas and Handest (2003) discuss the case of Thomas who "reported that he felt . . . quite different from other people since his very early childhood", while Elizabeth (Herrig, 1995, p. 339), in a First Person Account published in *Schizophrenia Bulletin*, reported that at school she felt "different and alone" and that she "wanted to blend in in the classroom as though I were a desk. I never spoke". Rosemary (Traynor, 1997, p. 167) reports that "[a]s a child I was actually never really happy. I could sense there was something wrong" while Mary (M. E. McGrath, 1984, p. 838) notes

> . . . I wonder if I ever knew myself, or merely played the parts that were acceptable, just so that I could fit in somewhere.

Similarly, Pamela (Wagner, 1996, p. 400) also suggests early feelings of oddness 'within':

> Early on, I was aware that something was terribly wrong with me, that something was 'odd within', though I never could have put a name to it or expressed the experience in words.

While, once again, such 'disturbances of self', when they are noticed at all by psychiatrists operating within the standard paradigm, are often thought to be due to 'dysfunctioning' neurobiology, support for the contention that such 'disturbances of self' may arise, at least in part, from early relational problems is provided by research from the field of 'attachment theory[8]'. For example, insecurely attached children, although intellectually equal to securely attached children at the age of 2 years, "are less persistent and enthusiastic when solving problems" (Meins, 1997, cited in Bentall, 2004, p. 468) suggesting problems with conceptualising themselves as someone who can make things happen in the world. Furthermore, at the age of 11 years insecurely attached children are "less able to recall specific incidents from earlier in life, and are less able to reflect on their own mental processes" (Bentall, 2004, p. 468), suggesting problems concerning autobiographical memory, an ontological skill central to 'Self 2'. This is in line with the findings already noted above that people diagnosed with 'schizophrenia' have difficulties recalling autobiographical memories.

Furthermore, a study by Fonagy and Meins (1997, cited in Bentall, 2004) has shown that insecurely attached children between four and six years of age "perform less well than securely attached children on a test designed to measure their ability to understand the mental states of other people" (Bentall, 2004, p. 468). This also suggests problems with the acquisition of 'Self 2' because one of the central aspects of being a 'self' in that sense is also being able to conceptualise others as 'selves', similar to though not identical to you. Indeed, as was outlined in Chapter Three, it is via our interactions with other 'selves' that we learn to become ourselves. As Parnas and Handest (2003, p. 126) note, this ability to 'understand the mental states of others' is often compromised in people with schizophrenia as illustrated by a comment they quote from a woman called Anne: "it is not the question of knowledge; it is prior to knowledge (. . .); it is so small, so trivial; every child has it!".

Indeed, as Bentall (2004, p. 469) points out, a number of studies suggest that people who become 'schizophrenic' show, or report insecure 'attachment styles', particularly those characterised as 'anxious-avoidant' and 'anxious-ambivalent'. As Bentall (2004, p. 470) points out, people with the 'avoidant' attachment style tend to "devalue the importance of attachments" and that they often cannot remember specific details about their relationship with their parents during their childhood. Again, this links to problems reported with autobiographical memory discussed above. A study by

[8] See Footnote 15 in Chapter Five regarding the way in which 'attachment theory', and the research which flows from it, is viewed and utilised in this thesis

Dozier, Stevenson, Lee and Velligan (1991, cited in Bentall, 2004) found that people with a diagnosis of 'schizophrenia', in comparison with those who were diagnosed with 'affective disorders' tended to have an 'avoidant' attachment style[9] and that such patients tended to be deluded, hallucinatory and suspicious.

Another study in which a large sample of people were administered questionnaires measuring attachments to others found that people with 'schizophrenia' as defined by the DSM-III-R (American Psychiatric Association, 1987) criteria, tended to have "an insecure and especially dismissing attachment style", while adolescents who showed high levels of psychoticism and paranoia were likely to have an attachment style that was either anxious-avoidant or anxious-ambivalent . As Bentall (2004, p. 470) notes people with an anxious-ambivalent attachment style "desperately want to have relationships, but feel in their hearts that no one will ever want to get close to them".

As Bentall (2004, p. 486) notes, while it might be pointed out that a sizeable minority of the population are 'insecurely attached' but only around one percent of the population is diagnosed as 'schizophrenic' "we must consider the importance of interactions between different risk factors for psychosis". Bentall (2004, p. 486) points out that a person who is securely attached might cope well with a violent or sexual assault, whereas someone who has grown up in a stressful and threatening environment and has an avoidant or ambivalent attachment style may respond by developing psychotic 'symptoms'. Indeed the same point has already been made above with respect to the studies showing the high rates of childhood sexual abuse in people who are diagnosed as 'schizophrenic'.

While the focus up to this point has been on the centrality of 'disturbances of self' due to early relational problems in the genesis of the experiences conceptualised as 'schizophrenic', these 'disturbances of self' alone are not enough to generate such experiences. As well as impacting on a child's senses of self, early relational problems have also been shown to exert disruptive effects on brain development, with changes occurring on multiple levels, from neurohumoral to structural and functional. As was noted in Chapter Four, Wismer-Fries, Ziegler, Kurian, Jacoris and Pollak (2005) suggest that "a failure to receive species-typical care disrupts the normal development of the OT (oxytocin) and AVP (arginine vasopressin) neurohypophyseal peptide systems in young

[9] Although it should be noted that this was reported by the patient rather than independently assessed.

children", systems which are "an integral part of mammalian emotional circuitry" (Wismer-Fries, 2005, p. 17,237).

These systems are suggested to be associated with the "emergence of social bonding, parental care, stress regulation, social communication, and emotional reactivity" (Wismer-Fries, 2005, p. 17,237). OT and AVP levels increase during socially pleasant experiences, such as comforting touch and smells which children who are being parented in an emotionally unresponsive, cold or harsh way would receive infrequently. As will be discussed below, stress regulation, social communication and emotional reactivity are all typically compromised in people who are diagnosed with 'schizophrenia'.

A number of studies also suggest that chronic stress and persistent glucocorticoid elevation may be particularly toxic to the hippocampus (Lim, Chong, & Keefe, 2009; Mirescu et al., 2004). A study by Mirescu, Peters and Gould (2004), suggests "that early adverse experience inhibits structural plasticity via hypersensitivity to glucocorticoids and diminishes the ability of the hippocampus to respond to stress in adulthood" (Mirescu et al., 2004, p. 841), a conclusion supported by clinical studies of people with a history of abuse who show evidence of a dysregulated[10] hippocampal system (Bremner & Vermetten, 2001) (Bremner et al., 2003).

Because, as Walker and DiForio (1997, p. 674) point out, "the hippocampus plays a pivotal role in the modulation of the HPA axis, structural abnormalities in this region would be expected to be linked with HPA dysfunction". Furthermore, as Lim, Chong and Keefe (2009, p. 405) point out, the hippocampus "is involved in crucial 'working memory' functions throughout childhood until the "prefrontal cortex reaches functional maturity and takes over this function".

As was outlined in some detail in Chapter Four, early adverse experience has a particularly toxic effect on the HPA axis, an aspect of human neurobiology which is particularly open to the effects of experience during development because of its extreme and lengthy post-natal plasticity (Perry, 2000; Pollak, 2005; Wismer Fries et al., 2005; Yates, 2007, pp. 10-11). As Yates (2007) points out, any alteration to these systems may negatively influence aspects of neuro-development such as synaptic pruning, dendritic branching, and neuronal death. Ultimately, the continuous activation of the HPA axis

[10] I will utilise this word to indicate differences in the ways in which the various neural systems of people who have been under chronic stress respond because it is very commonly used by researchers in the field. This does not imply an acceptance that the neural systems of people who have been under chronic stress are 'dysfunctional', they are simply functioning differently because of the different environmental contingencies to which they must respond.

(and associated changes in the functioning of other aspects of the central nervous system) may lead to deficits not only in brain development but also in social-emotional and cognitive functioning and the health and growth of the child.

Further illustrating the effect of relational damage on the stress response systems is research that shows that the cortisol levels of infants in insecure attachment relationships tend to elevate when they are upset (Gunnar et al., 1996) whereas those of children in 'secure' relationships do not. Research has also shown that the children of mothers who are 'emotionally unavailable' (either due to maternal depression or as a control tactic) also have higher baseline levels of cortisol (Bugental et al., 2003). As Bugental et al. (2003) note these elevated baseline levels of cortisol may be seen as reflecting levels of HPA activity which are characteristic of these children.

Furthermore, research also shows that the physiological stress responses of children who have 'disorganised/ disoriented' attachment relationships (associated with care-giving which is unpredictable, inconsistent and/or severely missattuned) deviate markedly from normative stress responses (Hertsgaard et al., 1995). This is in line with research by Bugental et al. (2003) suggesting that the children of mothers who use punitive control tactics (e.g., corporal punishment) at very young ages heightened children's reactivity to stressful situations. This suggests that when mothers become a source of stress rather than of support "at an age when children are as yet unable to regulate their behavior effectively children appear to become more susceptible to the effects of stressful events" (Bugental & Grusec, 2006, p. 244).

In light of this research, the well-replicated finding that people who are diagnosed as 'schizophrenic' also have dysregulated stress response systems suggests that such 'dysregulations[11]' could possibly have their genesis within a child's relationship with their first care-giver. For example, a study by Silber (1966, cited in Garmezy, 1974, p 71) showed, children considered to be at 'high risk' for developing schizophrenia were "highly labile autonomically, reacting to stress with rapid latencies and abnormal amplitudes" and that "their reactions were overgeneralized" which broadened the range of situations which were capable of stimulating their already sensitised stress response systems (Garmezy, 1974, p 71).

Further, in a review of the research on the relationship between stress and schizophrenia, Walker and DiForio (1997) stated that schizophrenia patients have been

[11] See Footnote 8.

found to show higher baseline levels of plasma cortisol and saliva cortisol than normal controls. In addition, when given the dexamethasone suppression test (DST) schizophrenic patients, unlike the vast majority of 'normal' controls, fail to suppress cortisol release, a finding which suggests a dysregulation of the HPA axis.

Interestingly such dysregulation of the stress response system[12] is also consistently reported in those diagnosed with affective disorders. As Davidson (2002, p. 478) notes, elevated activity of the HPA axis "is one of the most replicated biological findings in major depression". This is in line with the suggestion that a general vulnerability to psychological suffering is conferred via early relational problems which causes 'damage' not only to a child's emerging personal being, but also to their developing neurobiological tools. How that damage 'plays out' will depend on the particular nature of the damage (as discussed above) and what happens to the child as they move through their lifeline.

Thus, as was noted in Chapter Five the compounding difficulties at both the personal and molecular/organismic levels will, at all times during the child's development, 'feed back' on each other in the recursive manner characteristic of all dynamic systems. As was also noted in Chapter Five, the interactions between various components in a dynamic system may feed back upon themselves directly (a change in A causes a change in B which then changes A, etc.) or indirectly through a network of interactions.

This means that the effects exerted on each 'level' – the molecular, the organismic, and the personal-psychological – will also affect all the other levels, creating 'feedback loops' which can result in the emergence of patterns within a person that can prove particularly resistant to change. These feedback mechanisms can also mean that, paradoxically, systems may change quite suddenly and, seemingly, unpredictably. In hindsight, however, it is possible to see a series of changes which led the system into a state of 'self-organised criticality' (Horn, 2002).

As was noted in Chapter Five, such 'global reorganizations' occur at *phase transitions*; "points of instability and turbulence where old patterns break down and new ones occur" (M. D. Lewis, 2000, p. 39). Adolescence – the time between childhood and early adulthood, a time of life widely acknowledged to be a period of particular stress (Gotlib & Hammen, 1992; Bentall, 2004) even for people who have not experienced early

[12] This phrase encompasses not just the HPA axis but also related systems such as the NE-SAM (norepinephrine-sympathetic adrenomedullary) system, which are involved in the physiological stress response.

relational problems – is illustrative of just such a 'phase transition'. It is perhaps not surprising then that it is often either during adolescence or early adulthood that people become officially 'ill' with 'schizophrenia'[13].

As one of the major retrospective studies of the onset of schizophrenia, the Mannheim Age, Beginning, Course (ABC) study (Hafner et al., 1998) noted, the distribution of the age of onset (from the occurrence of the first 'sign' or 'symptom') showed an early and steep increase for men, with a pronounced peak between 15 and 25 years and a decrease in later years. For women the increase was less steep, with the peak lower and later, between 15 and 30 years of age.

While biological psychiatrists tend to focus on the changes occurring in the adolescent brain (see Strauch, 2003 for an overview of this research), as an explanation for why adolescence is a high-risk period for the first appearance of 'schizophrenia' there are also person-level factors that are just as, and quite possibly more, important. As Bentall (2004, p. 490) notes, adolescence

> clearly involves a number of developmental tasks, each of which may be seen as a hurdle at which the weak or ill-prepared may fall. In the ten years after puberty, the emerging adult must remodel her relationship with her parents, begin to explore sexual and emotional relationships with potential partners, and decide on a career path. Overarching these tasks, there is a need to establish an identity, a process that developmental psychologist and psychoanalyst Erik Erikson portrayed as the central problem of adolescence.

Bentall (2004, p. 490) further notes that research has shown that these challenges

> seem to provoke in adolescents traits that are reminiscent of characteristics often seen in psychotic patients: marked shifts of mood coupled with equally dramatic shifts in self-esteem; self-consciousness, egocentricity and grandiosity; magical thinking and a preoccupation with powerful role models and the fable of one's own life.

It should also be noted that the demands and challenges of life may actually be experienced as *more* stressful by people who become 'schizophrenic' than they are by other people. For example, research has shown that people who later develop 'schizophrenia' report greater subjective stress even though they do not appear to experience any more stressful events than 'normal' controls (Norman & Malla, 1993; Walker & Diforio, 1997, cited in Corcoran, Walker, Huot, Mittal, Tessner, Kestler et al., 2003). 'Schizophrenic' patients are also reported to "respond with more negative

[13] As will be discussed further in Section 6.3., adolescence is also a time when rates of depression begin to rapidly increase (Gotlib & Hammen, 1992).

emotions to everyday stressors than do controls" (Myin-Germeys et al., 2001, cited in Corcoran et al., 2003, p. 676).

This may be due to a complex mix of compounding person-level and organismic/molecular-level factors. For example, as was noted in Chapter Five, social challenges and relational difficulties (e.g., failing a test, being turned down for a job, being turned down for a date, etc.) may reactivate 'somatic markers' or embodied memories of childhood experiences that involved abandonment, rejection and humiliation. For children who were subjected to abuse, of physical and personal trauma such memories would be particularly 'malignant' (Schwarz, 1994).

At the organismic/molecular level the reactivation of such 'malignant memories' would initiate the body's stress response systems (Schwarz, 1994), already sensitized due to stress-induced vulnerability of limbic areas (Post, 1992; Post, Weiss & Leverich, 1994, cited in Harkness & Tucker, 2000) resulting in either hypo- or hyper-arousal (Perry, 2001, p. 5).

Schwarz (1994) suggests that such memories, and the physiological stress they aroused, would be experienced at the 'person-level' as intensely negative feelings (fear, anger, panic, etc.) accompanied by disturbing thoughts and bodily sensations over which the person would feel little control. As was noted in Chapter Five, such feelings may then stimulate behaviour that may seem 'hyperactive' or 'over-the-top', or, conversely, behaviour that is suggestive of hesitance, avoidance or numbness (Garmezy, 1974; Schwarz & Perry, 1994).

If people who later become schizophrenic do, due to relational difficulties with their first care-giver, experience events as more 'stressful' than 'normal' people do, then this suggests that any intensification in the demands placed on them, such as happens, for example, during adolescence, will be even more likely to precipitate the kind of changes representative of the 'signs and symptoms' of what psychiatrists refer to as the 'initial prodrome' of 'schizophrenia'. This would also suggest that the more dysregulated their stress response systems the more severe these 'symptoms' would be.

While there is not a lot of research on the underlying neurobiology of the prodromal symptoms, research concerning 'negative symptoms' which, as noted above, are similar, if not identical, to the prodromal 'symptoms', suggests there is an association between cortisol release and the severity of these symptoms (Walker & Diforio, 1997, p. 672). This indicates that symptom severity may be related to the severity of the dysregulations in the HPA system.

As White, Anjum and Schulz (2006, p. 377) note, "operationally, the prodrome is defined by duration of time, starting with the onset of decline in the baseline level of functioning and ending at the time when the criteria for a schizophrenia spectrum diagnosis are met". As these authors further note, this time period can be considered as a continuum, "with the level of risk increasing as the symptoms emerge or evolve during the prodrome" (White et al. 2006, p. 377). The Mannheim ABC study (Hafner et al., 1998) suggests that the prodromal phase lasts, on average, for five years and is followed by a pre-psychotic phase of around one year in duration during which positive symptoms (hallucinations, delusions, 'disordered' thoughts) first appeared and escalated.

While talk of an 'initial prodrome' suggests that when the person enters it they have moved from being 'normal' to being in the early stages of a 'disease process', the research cited above, and people's subjective accounts of their schizophrenic experience, do not support such a view. As has already been noted above, many of those who are later diagnosed as 'schizophrenic' have felt a sense of perplexity and/or oddness about their relationship with the social and material world since early childhood. Indeed, as has already been noted above, the so-called 'prodrome' could be seen as just another point in the developmental trajectory of persons trying to deal with the continuing repercussions of early relational difficulties, difficulties which profoundly disrupted their most basic sense of being in the world and the neurobiological systems which subserve it.

As Yung and McGorry (1996, p. 358) note, research suggests that the signs and symptoms of the 'initial prodrome' may include:

> (1) changes in affect – e.g., anxiety, depression, irritability, anhedonia, suicidal ideas and guilt; (2) 'changes in volition' – e.g., loss of motivation, loss of interest, loss of energy; (3) 'cognitive changes' – disturbance of attention, daydreaming, thought blocking; (4) physical symptoms – somatic complaints, loss of weight, poor appetite, sleep disturbance; (5) 'Other symptoms' – obsessive-compulsive phenomena, dissociative phenomena, change in sense of self, others, or the world, speech abnormalities, perceptual abnormalities, and suspiciousness.

As Romans and Seeman (2005, p. 125) note "non-specific symptoms and negative symptoms usually emerge first, followed by attenuated positive symptoms".

These changes will be experienced by the child/adolescent at a person-level as intensified suffering and an increasingly fragile and fragmented 'sense of self'. This sense of the self 'shattering' or 'disintegrating' occurs as the person progressively loses (due to the compounding effects of problems arising from their early relational difficulties coacting with current life-stress and reactivated 'malignant memories)

whatever tenuous hold they may have had during childhood on the 'mineness' of their experience (Self 1), their sense of 'self as agents' (the second and related aspect of Self 1), and their ability to conceptualise themselves, and present themselves, as a coherent unity of experience (Self 2).

This suggestion is supported by the work of Parnas and his colleagues (Parnas & Handest, 2003) (Parnas et al., 2005) (Parnas & Sass, 2002; Sass, 2002) (Cermolacce et al., 2007) who note that 'disturbances of self' essentially underlie the 'signs and symptoms' of the so-called 'initial prodrome'. For example, Sass and Parnas (2003) cite the results of a Norwegian early intervention project (Moller and Husby, 2000) that carried out in-depth interviews with 20 first onset schizophrenic patients and found that

> all patients had profound and alarming changes of experience of self; nearly all patients complained of the near-ineffability of their self-alteration; and the great majority reported preoccupation with metaphysical, supernatural, or philosophical issues.

In addition, such basic disturbances of self are "specific to the schizophrenia spectrum conditions" and are not found in other 'mental disorders' (Sass & Parnas, 2003, p. 437)'.

As Sass and Parnas (2003, p. 437) point out, "it is important to realize that the nature of the self-disorders in the prodromal or pre-psychotic phases may not be immediately obvious". As these authors go on to note

> typically, the patient complains that a profound change is afflicting him or her yet cannot pinpoint what exactly is changing because it is not a something which can be easily expressed in propositional terms.
>
> (Sass & Parnas, 2003, p. 437)

Often it is expressed by complaints of anxiety, lowered initiative and motivation, and depressed mood and may range from a seemingly innocuous "I don't feel myself" or "I am not myself" through to "I am losing contact with myself" or "Something inside me has turned inhuman" (Sass & Parnas, 2003, p. 437). Sass and Parnas (2003, p. 438) go on to note that patients may complain of being "occupied by, and scrutinizing, my own inner world" or of "excessive brooding [and] analyzing and defining myself and my thoughts".

As Parnas and Handest (2003, p. 125) point out, people in the early stages of schizophrenia will often "sense a sort of 'inner void' or a 'lack of inner nucleus', which is

normally constitutive of his field of awareness and crucial to its very subsistence". Some patients say things like "My consciousness is not as whole as it should be", "My I-feeling is diminished", "My I is disappearing for me", "It is a continual universal blocking". These authors further note that this sense of losing oneself is "frequently associated with diminished affectability or reactivity of the self" (Parnas & Handest, 2003, p. 125); a feeling which may underlie prodromal 'symptoms' such as depressed mood, anhedonia, and loss of motivation, interest and energy.

Other anomalies of self experienced by people in the early stages of schizophrenia include a feeling that their body no longer belongs to them (a disturbance of a fundamental aspect of Self 1), an alteration in the 'stream of consciousness' (a central aspect of Self 2) and problems with discriminating self from 'not-self' (once again the ability to this is part of Self 2). For example, Parnas and Handest (2003, p. 126) note that many patients describe "a variety of dissociations of the bodily experiential modes" with a "striking tendency to experience one's body predominantly as an object" illustrating "an increasing experiential distance between subjectivity and corporeality" a sense, in other words of 'disembodiment'. Patients complain that they are no longer in their body or note that while they can sense their body it is "far away, some other place" (Parnas & Handest, 2003, p. 126).

A common early change, according to Parnas and Handest (2003, p. 127) is "a sense of being detached, disconnected from one's body, which feels somehow alien or not 'fitting' the subject". Other people may feel a "loss of bodily coherence" where their body parts are felt to be disconnected from each other. Parnas and Handest (2003, p. 127) point out that "this experience may take on an alarming intensity" when the previously taken-for-granted unity of body and 'self' disintegrates creating "a sense of fragmentation accompanied by a (pre)-psychotic panic of literal dissolution ('going to pieces')".

As Parnas and Handest (2003) note, such 'disturbances' may also affect motor performance. People may 'involuntarily' speak or act in ways which interfere with what they were meaning to do although at this stage such speech or action is still regarded as their own rather than being imposed by some external agency. Indeed Parnas and Handest (2003) describe how a patient of theirs reported such involuntary speakings years before the onset of schizophrenia, indicating, as I have suggested above, that such disturbances may be present, albeit in a much less noticeable way, from very early on in a child's development.

The other aspect of 'self' which Parnas and Handest (2003) suggest is disrupted or disturbed during the upheavals of the 'prodromal' period is the 'stream of consciousness' – which was suggested, in Chapter Three, to be a central aspect of 'Self 2' as outlined by Harré (1998). Drawing on Meares (2000, p. 10) this 'stream of consciousness' was described as "a constantly changing fabric of inner experience, a kind of gossamer or 'shimmer' . . . which might vanish, leaving us with nothing". Parnas and Handest (2003), somewhat more prosaically, describe the 'stream of consciousness' as "a sense of consciousness as a temporal flux." As these authors go on to note,

> the self permeates this whole as its first personal perspective: *there is no distance between my thoughts and myself*. Apart from certain reflective acts, my thinking is at 'zero point of orientation'
>
> (Parnas & Handest, 2003, p. 127, author's italics)

That aspect of 'Self 1' which is "the sense of existing as a self-possessed subject of awareness or activity" (Sass, 2002, p. 253), then, is absolutely central to experiencing the 'stream of consciousness' as fully one's own – with no gap or fissure between "the self and its contents" (Parnas & Handest, 2003, p. 128). During the 'prodromal' phase of 'schizophrenia, however, just such fissure does, in fact, seem to develop, suggesting, once again, that a fundamental disturbance of 'Self 1' may be central to the schizophrenic experience. As Parnas and Handest (2003, p. 128) note,

> mental contents became quasi-autonomous, bereft of their natural ipseity dimension. Thoughts may appear as if from nowhere, are felt somehow ego-less, decentered or at a distance from the self. They may interfere with the ongoing stream of thoughts (*thought interference*), and are often described by the patient through specific private designations such as 'automatic', 'acute' thoughts, 'thought-tics', etc.

Parnas and Handest (2003) suggest that this sense of an "experiential fissure between the self and its contents" is very similar to the fissure which occurs between the 'self and its body' as described above. And in the same way that people still sense their body as their own, despite a growing sense of disconnection with it, the person, at this early stage, still essentially sees these 'thought-tics' as their own "and there is no sense of ongoing inner resistance or mental struggle (as in the case of obsession)" (Parnas & Handest, 2003, p. 128).

At this point people often report what Parnas and Handest (2003, p. 126) refer to as a "hyper-reflexive form of introspective experience". 'Hyper-reflexivity' is basically an "exaggerated self-consciousness in which a subject takes itself as its own object".

Sass (2002), drawing on Blankenberg (1971, 1991, cited in Sass, 2002, p. 260) suggests, that such 'hyper-reflexivity' is essentially "a consequence of the loss of natural self-evidence, of the normal sense of embeddedness in a framework" so that the person "must devote energy and a kind of active, conscious effort and control to processes that would normally take place automatically" (Sass, 2002, p. 260). Sass (2002) goes on to suggest that this need for effort may account, at least in part, for the lowered energy and general fatigue so common in schizophrenia.

For example, Parnas and Handest (2003, p. 128) quote a patient who "if a thought passed through his brain (. . .), he was forced to direct back his attention and scrutinize his mind in order to know exactly what he had been thinking". This patient, then, was not only experiencing a gap between his 'stream of consciousness' and his 'self', he also felt forced to examine the 'contents' of that stream of consciousness in the same way he might examine any other phenomenon in the world which he found 'perplexing'.

As Parnas and Handest (2003, p. 128) note, this

> tends to objectify the introspective experience: the content of experience is less lived and appears more like an inspected object. For example, inner speech becomes transformed from a medium of thinking into an object-like entity with quasi-perceptual characteristics.

This 'fissure' between the 'self and its contents' and the preoccupation with examining those 'contents' tends to rob the person of the sense of subjective mastery over their 'stream of consciousness' and it is experienced as increasingly alien or other (Parnas & Handest, 2003, p. 128). Patients report that they become increasingly obsessed with seemingly trivial matters that they themselves identify as trivial and yet they cannot stop thinking about them. Parnas and Handest (2003, p. 129) suggest that this state may intensify into a 'thought pressure' "where the patient is overwhelmed by a myriad of unconnected thoughts" or the person may experience a 'thought block' where thoughts suddenly disappear or fade away. Parnas and Handest (2003, p. 129, authors' italics) further suggest that such hyper-reflexivity may lead to "a peculiar and pervasive *splitting or a doubling of the self* into an *observing* and *observed* ego, none providing a reliable sense of ipseity." which "may intensify prior to a frank psychotic episode", as will be discussed below.

Another, and closely related, aspect of the prodromal experience of schizophrenia is the growing "inability to discriminate self from not-self", described by Bleuler (1911, cited in Parnas and Handest, 2003) as *transitivism*. Again, Parnas and

Handest (2003) suggest that such transitivism arises because of an increasingly deficient sense of the 'mineness of experience'. Parnas and Handest (2003) point out that in the prodromal phases of schizophrenia, or in so-called 'schizotypal' conditions, one may observe very subtle instances of transitivism which are "purely experiential, i.e., unaccompanied by delusional elaborations" (Parnas & Handest, 2003, p. 129).

These authors present as an example of this the case of a young man who, during conversations, was unable to distinguish between himself and the person he was talking to.

> He tended to lose the sense of whose thoughts originated in whom, and felt 'as if' his interlocutor somehow 'invaded him', an experience that shattered his identity and was intensely anxiety provoking. When walking on the street, he scrupulously avoided glancing at his mirror image in the windowpanes of shops, because he felt uncertain on which side he actually was.
>
> (Parnas & Handest, 2003, pp. 129-130)

As Parnas and Handest (2003, p. 130) point out, the various anomalies of experience linked to the profound disturbance in the basic sense of 'mineness' of experience shatters the experiential equilibrium and often results in people, during the early stages of schizophrenia, embarking on a metaphysical quest which can lead to existential reorientations. For these people 'reality' can start to seem somehow mind-dependent, physical causality "loses its regulatory ontological role", 'other minds' become either mysterious entities or "malevolent constructions", the distinction between self and others becomes blurred and normally unexamined 'mental processes' are subjected to intense examination.

This can result in the later stages of the prodromal phase of schizophrenia, in a solipsistic orientation being taken to the world, motivated by the now profoundly altered self-experience and elaborated by the person "into a nexus of interests and beliefs pointing to a new existential orientation" (Parnas & Handest, 2003, p. 130). Often prominent in this new orientation is a sense of their own centrality as evidenced by one of Parnas and Handest's (2003, p. 130) patients noting that

> When I hear a dog barking or a cat screaming far away, I instantly get the feeling that they bark and scream at *me*. When I listen to the radio, I get this thought that one is trying to let me understand something I know that it is pure rubbish.

It should be noted at this point that many of the 'symptoms' of the 'prodrome' (conceptualised by some psychiatrists as 'negative symptoms') remain even once the

person has begun to experience the hallucinations, delusions, disordered thoughts and 'disorganised' behaviour, which are typically regarded as the manifestations of psychosis (conceptualised as 'positive symptoms'). Interestingly, as Parnas and Handest (2003) point out, the 'disturbances of self' they suggest lie at the centre of the schizophrenic experience correlate with both the negative and positive symptoms of schizophrenia.

As has already been noted above, the end of the 'prodromal' phase is signalled by the emergence of psychotic 'symptoms' – hallucinations, delusions, 'disordered' thoughts and 'disorganised' behaviours (the so-called 'positive symptoms'). At the person-level, Sass (2002) suggests that the various 'anamolies of experience' precipitated by the very basic disturbance of self described above and the 'hyperreflexivity' these 'anomalies' create, are foundational for the emergence of psychotic 'symptoms'. Sass (2002) suggests that while the hyperreflexive ruminations engaged in by people in the early stages of 'schizophrenia' are attempts to compensate for a more basic loss, they will often have a counterproductive effect – further distancing the person "from any sense of naturalness or capacity for spontaneous action, thereby *increasing* the patient's perplexity and making it more difficult to break out of what can easily become a kind of self-propagating spiral" (Sass, 2002, p. 261).

Thus, the person who attempts "to reassert control and re-establish a sense of self by means of introspective scrutiny may end up exacerbating his self-alienation and fragmentation" (Sass, 2002, p 261). It is suggested that the Western preoccupation with achieving a bounded, coherent and unified self would make just such a tactic more likely. As one of Sass's (2002, p. 261) patients notes, "My downfall was insight . . . Too much insight can tear your mind apart". Interestingly, introspectionist studies with 'normal' people show that such hyperreflection, even if it is produced voluntarily, can bring on similar alterations of the sense of 'self' and the world that are "strikingly reminiscent of what occurs in schizophrenia" (Hunt, 1985, 1995; Sass, 1994, cited in Sass, 2002, p. 262).

Sass (2002) suggests that there is also an even more basic kind of hyperreflexivity which occurs in 'schizophrenics' where the person comes to reflect on themselves or aspects of their functioning in a "host of other, more passive, automatic, or 'pre-reflective' ways". These kinds of hyperreflexivity include experiences in which the "normally transparent field of experience can become increasingly disrupted by a kind of automatic and passively experienced popping up of unusual sensations, feelings, or thoughts that come to acquire object-like quality" (Sass, 2002, p. 262).

In the early 'pre-morbid' stages of 'schizophrenia', patient reports suggest that this kind of hyperreflexivity is experienced "as a largely passive process, more like an affliction" (Sass, 2002, p. 262). It usually involves *cenesthesias* (a loss of the automaticity of movement) and certain disturbances of thought and perception, which have been designated with the term 'basal irritation'. As Sass (2002, p. 262) points out, these experiences "appear to involve hyperreflexive awareness of sensations and other phenomena that would not normally be attended to in any sustained fashion". While such experiences very rarely occur in other 'mental disorders' they are very similar to experiences reported by 'normal' people who voluntarily adopt "an abnormal kind of detached, introspective stance toward their own bodily experiences" (Angyal, 1936; Hunt, 1985, 1995; Sass, 1994, cited in Sass, 2002).

Such hyper-awareness of bodily sensations and other phenomena that would usually not be attended to, in common with the hyperawareness of one's own thoughts and actions, is driven, then, by very basic disturbances in the sense of oneself as a "self-possessed subject of awareness or activity" (Sass, 2002, p. 253). That hyper-awareness, or 'hyperreflexivity' then, in turn, creates more 'anomalies of experience', creating the 'need' for an ever-increasing degree of hyperreflexivity as the person struggles to compensate for, and to understand, their increasingly fragmented experience of being in the world.

Longitudinal studies of premorbid and prodromal symptoms of schizophrenia cited by Sass (2002, p. 263), illustrate this struggle showing "a progressive shift from 'basal irritation' to full-blown first-rank symptoms through increasing objectification and externalization of normally tacit inner phenomena". Such studies show, suggests Sass (Sass, 2002, p. 263), that each of the first rank symptoms "are generally preceded by subtle subjective experiences of alienation occurring in the same experiential domain" (e.g., bodily sensation, thought, perception) which then become "externalized and thematized in the form of first-rank symptoms affecting that realm".

Sass (2002, p. 263) suggests that this essentially occurs because to have awareness of what is usually tacit objectifies or alienates the phenomenon and "causes it to be experienced as existing at some kind of remove from what Husserl (1989) called the 'zero point' of orientation of ongoing experiential selfhood". Thus, in extreme instances the person can "lose the sense of inhabiting his own actions, thoughts, or sensations and may feel that these are under the control of some alien being or force". At this point, as Parnas and Sass (2003) note, the person loses any sense of autonomy they may have had and feels 'at the mercy of the world'.

As has already been noted above, the hyperreflexivity driven by the original 'disturbance of self', also tends to lead to an obsession with existentialist philosophies and/or religious themes. This obsession usually starts during the prodromal phase but continues and intensifies as the person becomes increasingly more anxious (Parnas & Handest, 2003). Very often it is these religious or existentialist ideas that provide the 'themes' for the hallucinations and delusions experienced by people with 'schizophrenia'. Alongside, and often informed by, the religious and existential ideas the person has begun to explore, the feelings of 'centrality' which first started to emerge during the prodrome also intensify during the 'psychotic' phase resulting in 'delusions of grandeur'. During such delusions the person may identify him or herself as, for example, Jesus Christ, the Buddha, the Virgin Mary or Satan.

As Parnas and Sass (2002, p. 131) point out, a number of authors have noted that there is a "characteristic metaphysical colouring" of the contents of 'schizophrenic' delusions, a 'colouring' which "helps to distinguish them from non-schizophrenic delusions". Parnas and Sass (2002, p. 131) suggest that "the 'metaphysical taint' [of these delusions] indicates something about the nature of the experienced self-relation: that is to say, it points to a disturbance of self as the founding instance".

It is suggested, however, that while the 'anomalies of self' identified by Parnas and his colleagues are foundational for the experiences of both the 'prodromal' and 'psychotic' phases of 'schizophrenia' they are not, in and of themselves, enough to result in a psychotic breakdown. There must also, it is suggested, be increasing levels of personal stress (which may or may not be due to a proximal trauma) impacting on already dysregulated stress response systems, the effects of which then reverberate through every aspect of a person's being – personal, organismic and molecular – and coact with the person-level 'anomalies of self' outlined above.

This suggestion is supported by research indicating that "[u]nusual stress appears to be necessary for the fundamental development of psychosis" (McGlashan & Johannessen, 1996, p. 204). For example, a study by Romme and Escher (1989, cited in Morrison et al., 2003) found that 70% of voice hearers developed their hallucinations following a traumatic event, and they suggested that hearing voices may be part of a coping process. Furthermore, a study by Honig et al. (1998, cited in Morrison et al, 2003), comparing the form and content of chronic auditory hallucinations in three cohorts (patients with schizophrenia, patients with a dissociative disorder, and non-patient voice-hearers), found that, in most patients, the onset of auditory hallucinations was preceded by either a traumatic event or an *event that activated the memory of earlier trauma*,

and that the disability incurred by hearing voices was associated with the reactivation of previous trauma and abuse. It should also be noted here that the 'disability' incurred by hearing voices would also have been associated with the fact that in the West experiencing hallucinations of any kind is considered to be a signifier of 'madness', which would, in and of itself, be extremely anxiety inducing. In a culture where hearing voices was considered nothing out of the ordinary it is quite possible that 'disability' may not be incurred at all, as will be discussed further below.

These findings highlight the fact that the proximal source of stress does not necessarily have to be, in and of itself, 'traumatic' in order to be experienced as stressful. As already noted above, people who develop 'schizophrenia' report greater subjective stress even though they do not appear to experience any more stressful events than 'normal' controls (Norman & Malla, 1993; Walker & Diforio, 1997, cited in Corcoran, Walker, Huot, Mittal, Tessner, Kestler et al., 2003, p. 676). As has also been suggested above, one of the reasons for this sensitivity to stress may be that later life stress reactivates what Schwarz (1994) conceptualises as 'malignant memories' thus precipitating a cascade of person-level and organismic/molecular level responses which may precipitate a change in 'state', in dynamic systems terminology.

For those whose first care-givers failed to meet their basic relational needs – these malignant memories would be extremely stressful, stressful enough on top of the compounding effects of early damage, including the disturbances of self described above and disturbances of the brain's stress response systems, to precipitate psychosis. For those who also experienced childhood sexual abuse, which, as already noted above, is extremely prevalent amongst people diagnosed as 'schizophrenic', the memories may be almost as traumatic as the original abuse, thus leading to an even more extreme stress response and generating even more florid psychotic experiences.

This suggestion is supported by the 'dose-response' relationship found by a large number of studies (see, for e.g., Read et al., 2005) between florid psychotic symptoms – in particular delusions and hallucinations (both auditory and visual) – and childhood sexual abuse – "the more severe the abuse the stronger the relationship" (Read et al., 2005, p. 339).

Furthermore, Bentall (2004, p. 491) notes that another source of proximal stress prior to the psychotic breakdown may simply be the

> mere inability to adapt to new demands, to cross hurdles which brothers, sisters, friends and neighbours stride over with relative ease [which] may be sufficient to instil a sense of

> failure and personal inadequacy, magnify pre-existing social-cognitive peculiarities, and provoke thoughts that are increasingly psychotic.

Thus, it is suggested, psychotic 'symptoms' arise, in the same manner as 'prodromal symptoms', out of the coactions between a person's already disturbed 'senses of self', their already dysregulated stress response systems and intensifications in proximal sources of stress. As with the 'symptoms' of the 'prodrome', studies have found that there is an association between cortisol release and the severity of psychotic 'symptoms' in both medicated and non-medicated patients (Rybakowski, Linka, Markowski & Kanarkowskit, 1991; Franzen, 1971, cited in Walker & DiForio, 1997).

Another study suggested that cortisol levels were significantly higher (250%) immediately prior to psychotic episodes in comparison to periods of recovery (Sachar, Kanter, Buie, Engle and Mehlman, 1970 cited in Walker & Diforio, 1997). When the subjects were actually psychotic the cortisol levels fell to midway between pre-episode and recovery levels. As Walker and DiForio (1997) point out, "this is consistent with the assumption that elevated cortisol release precipitates symptom exacerbation, rather than being solely a consequence of it".

It should be noted at this point that psychotic disturbances are not particular to 'schizophrenia'; they can also occur in 'major depressive disorder', 'post-traumatic stress disorder', 'borderline personality disorder', 'bi-polar disorder', and in the 'normal' population (Bentall, 2004). Such disturbances, for these people, are often precipitated by, or associated with, trauma of one kind or another, as they are for those diagnosed 'schizophrenic'. Read, van Os, Morrison and Ross (2005) cited a study, for example, which indicated that 'bi-polar' patients who had experienced childhood sexual abuse also had high rates of auditory hallucinations. Indeed, only one of the severely abused patients this study did not experience auditory hallucinations.

It should also be pointed out that studies have also shown that many of the 'neuropathologies' found in those diagnosed as 'schizophrenic' – all of which could be explained by glucocorticoid-related neurotoxicity – are also found in a number of other 'mental disorders', including 'major depression', 'bi-polar disorder, and 'post-traumatic stress disorder' (Bentall, 2004; Walker & Diforio, 1997). Both these bodies of research provide support for the contention that not having their basic relational needs met during infancy and early childhood may confer upon people a general vulnerability to psychological suffering of all kinds.

As was noted in the introduction, however, what makes the difference between how such generalised vulnerabilities may 'play out' as particular kinds of suffering, is to be found in the complex trajectories of each individual life out of which emerges their own unique cluster of 'sufferings'. What is being suggested, then, is that people who experience early relational difficulties of a very particular sort – wherein the caregiver is unresponsive, neglectful and emotionally cold and, possibly, physically harsh – will be more likely to experience the particular cluster of 'sufferings' thought to typify the 'disorder' called 'schizophrenia', as outlined in the DSM-IV-TR (American Psychiatric Association, 2000) and the self-reports of many of those so diagnosed.

The particularities of experience involved in this 'cluster of sufferings', it is suggested, have their foundations not in disordered neurobiology (as has already been noted, such disordered neurobiology is necessary but *not* sufficient for the emergence of 'schizophrenia'), or in high levels of proximal stress (again, necessary but not sufficient), but in their early social interactions; interactions which do not adequately enable the emergence of the most basic 'sense of self', the sense of 'mineness' of experience or 'ipseity' as discussed in some detail above.

It must also, of course, be stressed, that this does not mean that such 'disturbances of self' are, in and of themselves, sufficient for the experiences conceptualised as 'schizophrenia' to arise. 'Schizophrenia', like all other 'mental disorders', does not have one underlying 'cause', rather it depends for its emergence on increasingly complex coactions occurring over the course of a person's lifeline between person-level factors, neurobiological factors and proximal and distal life stresses.

It is suggested, however, that given the compounding nature of these coactions, the more profound the early damage (the more unresponsive, neglectful, emotionally cold and physically harsh the caregiver), particularly if it is accompanied by childhood sexual abuse (which seems to intensify the psychotic symptoms thus making it more likely the person would come to the attention of a mental health professional), the more likely a person will end up with an official diagnosis of 'schizophrenia'.

If the early relational difficulties between a child and their first care-giver are less profound then the person may well end up, depending on what happens to them during their development, with another cluster of 'sufferings' some of which, for some of them, may overlap with the 'schizophrenic' cluster, others of which will not. This contention is supported by the fact that there are a number of people who have a mixture of 'symptoms' from a range of 'mental disorders', making it particularly difficult to decide

which 'mental disorder' they really have. For example, Bentall (2004) notes that many people have some of the symptoms of both 'schizophrenia' and 'bi-polar disorder', making these two disorders particularly difficult to diagnose 'correctly'.

The same point could be made concerning the overlap between the 'symptoms' of 'schizophrenia' and a number of other 'mental disorders' (e.g., 'major depressive disorder', 'borderline personality disorder', 'antisocial personality disorder', 'schizotypal personality disorder', etc., etc.). As White (2006) notes, it is often difficult, particularly during the early stages of schizophrenia, to decide whether the patient has an 'affective disorder', 'borderline personality disorder' or 'antisocial personality disorder'. This is because, essentially, each person has their own unique lifeline and hence their own unique 'cluster of sufferings'.

It should also be noted at this point that just because one has received the diagnosis of 'schizophrenia' does not necessarily mean that one has experienced such profound early damage. The diagnosis is often given to people whose 'cluster of sufferings' would, in the context of the disorder-based system we currently use, sit more comfortably under some other diagnostic category. Indeed, people often tend to get the diagnosis of 'schizophrenia' if they exhibit any sort of psychotic symptoms, hence the difficulty for psychiatrists in attempting to work out whether someone is 'bi-polar' or 'schizophrenic'.

Indeed, such diagnostic gymnastics exemplify one of the many problems inherent in any attempt classify someone as X or Y; people who are experiencing their own particular 'cluster of sufferings' will be boxed into the cluster listed in the DSM-IV-TR depending on whether they have the symptom(s) their psychiatrist/psychologist personally thinks are particularly representative of X. Another psychiatrist/psychologist may think their symptoms are more representative of Y. And so it goes on. As Smail (Smail, 1987, p. 12), himself a clinical psychologist, notes, he has several times

> observed at first hand the label 'schizophrenic' being attached to someone on no better grounds than that they accounted for their emotional unease in terms judged by their psychiatrists to be 'pseudo-philosophical'

As noted above, 'psychotic' experiences may be the endpoint of a number of alternative developmental trajectories and do not require the kind of profound early 'damage' being suggested to contribute towards a vulnerability to the cluster of sufferings conceptualised as 'schizophrenia' in order to manifest itself. Indeed, as Bentall (2004) notes, research suggests that the outcome for people with the same

diagnosis is enormously variable, with some remaining 'ill' for the rest of their lives, others completely 'recovering' and others having intermediate outcomes. It is suggested that the more profound the early damage to the 'self' the less likely a person is to move beyond the 'schizophrenic' experience, particularly if they are treated as if they are 'chronically mentally ill' by those around them, and expected to remain so for the rest of their lives.

6.3. DEPRESSION

According to the DSM-IV-TR (American Psychiatric Association, 2000), a 'major depressive episode' is characterised by the presence of five or more of the following symptoms over the course of a two-week period, representing a change from a person's previous functioning:

1. Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful). (In children and adolescents, this may be characterized as an irritable mood.)
2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day.
3. Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day.
4. Insomnia or hypersomnia nearly every day.
5. Psychomotor agitation or retardation nearly every day.
6. Fatigue or loss of energy nearly every day.
7. Feelings of worthlessness or excessive or inappropriate guilt nearly every day.
8. Diminished ability to think or concentrate, or indecisiveness, nearly every day.

9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

A diagnosis of Major Depressive Disorder (MDD) can be made if a person meets the criteria for experiencing a major depressive episode. MDD becomes recurrent, according to DSM-IV-TR (American Psychiatric Association, 2000), when a person experiences two separate depressive episodes with a gap between episodes of at least two months (American Psychiatric Association, 2000). MDD is very common with studies suggesting that approximately 5 percent of the adults in the United States and Canada meet the criteria for MDD at any given time, although rates of MDD do vary between countries with 0.8% of Taiwanese meeting the criteria for MDD and 5.8% meeting the criteria in New Zealand (see Richards & Perri, 2002).

As Bentall (2004, p. 243) points out, research into the 'cognitions[14]' of those diagnosed with 'depression' has established that the thinking of people who are depressed is "dominated by a negative view of the self, the world and the future" (Beck, 1976, cited in Bentall, p. 239). Beck (1976, cited in Bentall, 2004) refers to this attitude as 'the negative cognitive triad' and suggests that such "automatic or unbidden thoughts . . . are the immediate precursors of dysphoric mood" (Bentall, 2004, p. 239). Another group of cognitively oriented researchers, led by Abramson and Seligman (Abramson, Seligman & Teasdale, 1978, cited in Bentall, 2000, p 239), have found that depressed people "make excessively internal, global and stable attributions for negative events" and research suggests that this 'attributional style' may precede the onset of 'dysphoria'.

As Bentall (Bentall, 2004) further notes, while Abramson, Seligman and colleagues (Abramson, Seligman & Teasdale, 1978, cited in Bentall, 2000, p) focused on the last aspect of Beck's (1976, cited in Bentall, 2004) 'cognitive triad', arguing that "excessively stable and global attributions for negative events lead to a sense of hopelessness", research suggests that negative 'attributions' about the first element in Beck's (1976, cited in Bentall, 2004) triad – the self – are even more fundamental to 'depression'.

[14] Current research into the genesis of depression research tends to be dominated by two main strands of theorising – (a) that the origins of depression lie in our 'cognitive styles', in other words we become depressed because of problems with the way we think and (b) that the genesis of depression lies in our neurobiology – we become depressed because of problems with our neurobiology.

This suggestion is supported by the large number of studies which consistently emphasise how negatively depressed people feel about themselves (e.g., Beck, 1967; Pietromonaco, 1985, cited in Carnelly & Pietromonaco, 1994}, how they expect more negative events to happen to them and less positive events (e.g., Pietromonaco & Markus, 1985; Pietromonaco & Rook, 1987; Pyszczyniski, Holt & Greenberg, 1987, cited in Carnelly & Peitromonaco, 1994), and that they recall more negative and less positive information about themselves (e.g., Derry & Kuiper, 1981; MacDonald & Kuiper, 1984; Teasdale, Taylor & Fogarty, 1980, cited Carnelly & Peitromonaco, 1994).

As William Styron (1990, p. 5) notes in his 'memoir of madness' *Darkness Visible*;

> Of the many dreadful manifestations of the disease, both physical and psychological, a sense of self-hatred – or, put less categorically, a failure of self-esteem – is one of the most universally experienced symptoms, and I had suffered more and more from a general feeing of worthlessness as the malady had progressed.

In line with these findings a study by Brown, Andrews, Harris, Adler and Bridge (1986) found that low self-esteem was a statistically and clinically significant factor in conferring vulnerability to 'depression'. Furthermore, a prospective study by Andrews and Brown (1988, p. 99) found that "low self-esteem . . . was associated with a considerably increased risk" of depression. As Strauman and Kolden (1997) note, the research of Brown and his colleagues (G.W. Brown, Bifulco, Veiel, & Andrews, 1990) (George W. Brown et al., 1986) suggests that "self-esteem is the most prominent immediate causal locus for the indirect effects of vulnerability factors such as childhood loss or abuse experiences, temperament, and socioeconomic influences" (Strauman & Kolden, 1997m p 9).

As Strauman and Kolden (1997, p. 9) further note, "the findings of Brown et al. (1986) are particularly important because they demonstrate that for many individuals, low self-esteem preceded the onset of their initial depressive episode". More recent investigations using large community samples and sophisticated statistical modelling lead to similar conclusions (Strauman & Kolden, 1997). Research also suggests that low self-esteem and negative self-evaluation contribute significantly to the maintenance of depressive episodes and to the likelihood of relapse and recurrence (Strauman & Kolden, 1997).

The re-analysis of the results of a study of the gender differences in the levels of 'rumination' by Nolen-Hoeksema, Larson and Grayson (1999) also illustrates the centrality of negative evaluations of the self to the cluster of sufferings conceptualised as

'depression'. As Treynor, Gonzalez and Nolen-Hoeksema (2003, p. 247) point out, "rumination is a method of coping with negative mood that involves self-focused attention . . . it is characterized by self-reflection . . . as well as a repetitive and passive focus on one's negative emotions". As these authors further note, research has consistently shown that rumination "predicts greater depressive symptoms . . . [and] . . . predicts the onset of major depressive episodes" (Treynor et al., 2003, p. 248).

After constructing a measure of rumination that was not confounded with 'depression' content, Treynor et al. (2003) found support for a two-factor model of rumination. They called the first factor 'reflection' and the second factor 'brooding'. The items on the reflection factor suggest "a purposeful turning inward to engage in cognitive problem solving to alleviate one's depressive symptoms", while those on the brooding factor reflect "a passive comparison of one's current situation with some unachieved standard" (Treynor et al., p. 256).

Treynor et al. (2003) also found that although women scored higher than men on both the reflection and brooding factors, suggesting women are generally more contemplative than men, "only when this contemplation takes the form of brooding is it associated with greater levels of depression in women compared to men". Treynor et al.'s (2003) re-analysis of the data of an earlier study by Nolen-Hoeksema, Larson & Grayson (1999) suggested that it is a low sense of mastery, rather than the existence of chronic stressors as suggested by Nolen-Hoeksema et al. (1999) that "contributes primarily to brooding – that is, to a passive contemplation of what's wrong in your life and how you wish it were better" (Treynor et al., p. 257).

The sense of 'self' which, it is suggested, is so 'fragile' or 'insecure' in those who are vulnerable to 'depression' is that aspect of the 'self' Harré (1998) calls Self 2 – our sense of ourselves as a continuous unity through time, with a set of unique skills and attributes and a past, present and future which we can 'narrate' both to ourselves and to others. This aspect of the self includes the sense of the 'self as stream of consciousness'; the almost continuous silent 'chatter' which we see as representative of our 'mind' or our 'inner self'. Again, as has already been noted several times in this thesis, this 'sense of self' is conceptualised as particularly 'inner', private, and essentially separate from other 'selves'. It is also this sense of 'self' which is felt to be the 'essence' of the person one feels oneself to be and which represents what is commonly thought of as the 'self'.

Central to Self 2 is the 'self-concept', which essentially encompasses all the things we believe about ourselves. These things may be reported to ourselves, or to others (Self

3) and may change quite considerably over time. Harré (1998) suggests that among the more lasting, and consistent, contents of our self-concept are beliefs about our capacities and powers, although even these change as we move through our lives. A crucial aspect of a person's self concept is the beliefs they have about the worth or value of their 'self'. This judgement of 'self' has generally been referred to within psychology as 'self-esteem', an aspect of the self, as noted above, which is particularly central to the cluster of sufferings conceptualised as 'depression'. The research outlined above seems to be indicating that people who become depressed not only tend to accord a low value to their 'self', but also that their self-concept is very fragile and prone to changing as situations change.

As was outlined in Chapters Three and Five, the origins of our sense of who we are and the value we assign to our 'self', emerge from within our early interactions with our first caregiver. It is within the context of these interactions that we learn the ontological skills necessary to 'achieve' such senses of self, and it is within the context of those interactions that we absorb the 'feeling tones' which permeate our early lives and which lay the foundations, according to Meares (2000), for the value we accord to our 'self'. In light of the analysis being developed in this thesis, then, it is possible that the roots of 'depression' may lie in caregivers being unable to establish and/or maintain the kind of intense, emotionally and physically close relationship with their infants that is essential to the emergence of a relatively stable[15] and valued sense of 'self'[16].

As Meares (2000) points out, this kind of relationship requires the caregiver to respond to their infant in a way that creates "a feeling of 'fit' with the immediate experience of the baby". Such attunement creates a pleasure, suggests Meares (2000), which does not just arise from within the baby, rather it is "engendered by the harmonious connectedness between the baby's state" and the state of those with whom s/he is interacting, at this stage usually the mother (Meares, 2000, p. 69). If the mother is unable to do this then such 'failures of attunement' will severely compromise the "particular form of pleasure upon which value [accorded to the self] depends" (Meares, 2000, p. 68).

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[15]This is not to suggest that anyone's 'sense of self' is entirely stable. As Harre (1998) notes, our ideas and feelings about ourselves can shift considerably over time. The word 'stable' as used here simply means that one's feelings about oneself do not shift very easily and quickly from situation to situation.

[16] This suggestion is broadly in line with the position of the object-relations tradition within psychodynamic psychology which postulates that relationships between infants and their caregivers can result in problematic 'representations' of the 'self' or 'self-with-significant-other' which confer vulnerability to depression (see for e.g., Blatt & Homann, 1992). As will become obvious as the analysis proceeds, however, while there are some similarities between the approach being developed in this thesis and the object-relations approach, there are also some significant differences.

If such 'fit' is not achieved between the mother and the baby, Meares (2000) suggests, then the pleasure inherent in the 'conversation' for both partners is lost and the infant experiences 'disjunctional anxiety'. Meares (2000) suggests that if such 'misattunements' are chronic this 'disjunctional anxiety' permeates the child's experience of life with a primarily negative 'feeling tone', and this feeling tone, via the processes discussed in Chapter Three, becomes 'embodied'. It becomes, in other words, an aspect of one's 'personal being' and as such is 'woven into' the 'senses of self' that comprise that personal being. As was pointed out in Chapter Three, such embodied feelings are thus there right from the beginning and they remain at the core of our experience throughout our lives, and "whether we recognise their influence or not, [these] feelings are always present: shaping our goals, biasing our evaluations, and guiding our attention" (Cromby, 2006b, p. 14).

Thus, it is suggested that the 'self' that would arise out of such asynchronous interactions would be a 'self' whose experience and reality has not been 're-cognised', a self who has not experienced the pleasure that arises as a consequence of such recognition, a self who would find it very difficult to accord value to their 'self without outside 'help' (social relationships or roles which confer value upon the 'self'), as will be discussed further below, because they would not have embodied a sense of that 'self' as being valued, and thus as being valuable, during the time that 'self' was being forged.

It should be noted before going any further that while it is the contention that all instances of 'depression' are essentially precipitated by 'threats to the self' of one form or another, a person does not have to have experienced the kind of early relational problems which will be outlined in this chapter to become depressed in response to a major life stressor. As was noted in Chapter Five, because of the centrality of the notion of the autonomous, private and essentially separate 'self' to personal being in the West we are all, to a certain extent, 'vulnerable selves'.

As Shweder (1984) notes, Westerners have essentially "cut . . . the self off from the interdependent whole" which not only makes us more vulnerable to feelings of isolation and loneliness, but also makes it very likely we will locate the source of our problems 'inside our selves', and thus blame ourselves. As Schumaker (2001) points out there are a number of discourses in the West around 'personal responsibility' which overtly encourage this, thus providing fertile soil for the 'negative attributions', 'low self-esteem', and feelings of guilt which are so central to many of our 'mental disorders' in the West.

The focus of the following analysis, however, will be on the genesis of experiences that are towards the more severe end of the spectrum of sufferings conceptualised as 'depression'. These severe and chronic depressions have often been theorised in the past to be 'endogenous' ('of the body') as opposed to 'reactive', partly because they are often experienced by those who suffer them as having come 'from out of nowhere'. Thus, while it is the contention that all 'depressions', even mild ones, are precipitated by 'threats to the self' of one sort or another, in order to experience the kind of severe depressions which are the focus of this discussion one must have been involved in interactions with a primary care-giver which did not meet some of the basic relational needs of the human infant, as outlined in Chapter Three, and which thus 'damage' the child at the molecular, organismic and the person level as will be further discussed below.

Interestingly, and in line with the current analysis, the endogenous-reactive distinction, though still utilised by practitioners, has not received a lot of empirical support and is not considered a valid diagnostic distinction (Gotlib & Hammen, 1992). For example, the results of studies by Frank, Anderson, Reynolds, Ritenour & Kupfer (1994) and Brown, Harris & Hepworth (1994) suggest that the seeming disconnection between severe life events and the onset of a depressive episode in 'endogenous depressions' disappears when only first episodes of depressions characterised by the endogenous symptom pattern are considered.

When this is done the rate of severely threatening life events and their proximity to episode onset is quite comparable with the rate observed in patients with a 'non-endogenous' symptom pattern. This suggests that the main difference between so-called 'endogenous' and 'non-endogenous' depression may lie in its severity, its chronicity and, in most cases, the earliness of its onset. This is in line with the finding that early onset depression is associated with high recurrence risk (Kessler & Magee, 1994).

Furthermore, Harkness and Monroe (2002, p. 387) found that "severe physical abuse, sexual abuse, antipathy, and neglect, as well as both high and lax levels of supervision and discipline", were significantly associated with the kind of depression commonly conceptualised as 'endogenous[17]'. As Harkness and Monroe (Harkness & Monroe, 2002, p. 390) note, endogenous depression "has traditionally been associated with a neurobiological etiology and it is compelling to find it here preceded by severe environmental adversity".

[17] Now more commonly known as 'melancholic depression' and long thought to be biological rather than environmental in origin (Peselow, Sanfilipo, Difiglia, & Fieve, 1992).

It is suggested that the ways in which depressed[18] mothers interact with their children may offer some valuable insights into what sort of relational difficulties may confer upon people a particular vulnerability to the cluster of suffering conceptualised as 'depression', and how this vulnerability might be conferred. As was outlined in Chapter Five, there is a large body of evidence suggesting that parental, and in particular maternal, depression is correlated with a number of adverse outcomes for children (Downey & Coyne, 1990; Beardslee, Versage, & Gladstone, 1998; Gelfand & Teti, 1990; Hammen & Brennan, 2003). One 'adverse outcome' which research suggests is particularly likely for the offspring of depressed women is, perhaps not surprisingly, 'depression'.

As a study by Hammen and Brennan (2003), using a large community sample, noted, "children exposed to maternal depression prior to age 10 years (and before the onset of a youth disorder) were twice as likely to have major depression or dysthymic disorder [before the age of 15] as children of never-depressed mothers". Furthermore, research shows that maternal depression has a much greater impact on the later development of depression in offspring than does paternal depression (Kessler, 1997; Shiner & Marmorstein, 1998), a finding which suggests that the way in which depressed mothers interact with their children may be the primary means of conferring this vulnerability.

Before proceeding, however, it is important to note that the kinds of parenting behaviours that are characteristic of depressed women are also found in women who are distressed or under stress, but who would not necessarily be diagnosed as 'clinically depressed'. For example, as was pointed out in Chapter Five, women raising children under the stresses of poverty are often found to be "are less nurturant, less supportive, and less inductive in their parenting than middle-class mothers" (McLoyd & Wilson, 1991, p. 111). Women attempting to raise children alone, particularly if they are also economically disadvantaged, as Eisenberg (1990, p. 11) points out, can experience increased "difficulty meeting the needs of their children".

[18] It should be noted that while the research into the effects of maternal 'depression' on offspring accepts the diagnostic category of 'depression' as a 'mental illness' uncritically this does not negate the importance of the findings of such research to the argument being put forward in this thesis. While it is argued in this thesis that there is no such thing as the 'mental illness' called 'depression', it is *not* being argued that people do not experience the kinds of suffering which are conceptualised as 'depression' and the research concerning maternal 'depression' very strongly suggests that such suffering exerts an impact on both the way in which women 'mother' their children, and that the children of women who are, or who have been, 'depressed', are highly likely to suffer from 'depression' themselves.

A number of studies, for example, have shown the quantity and the expressiveness of infant-directed-speech or 'motherese' to be adversely affected in women who are depressed (Teasdale, Fogarty & Williams, 1980; Scherer, 1986, cited in Reck, Hunt, Fuchs, Weiss, Noon, Moehler, et al., 2004; Bettes, 1988). It is this kind of speech which is commonly used in the 'proto-conversational' interactions suggested in Chapters Three and Five to be central to the emergence of a unified, coherent and valued 'Self 2'.

As Bettes (1988) points out, maternal vocalisations to infants are regularly spaced and both the utterances and the pauses are very short, usually less than a second. Motherese vocalisations are also "intonationally simplified and exaggerated in both pitch range and duration" (Bettes, 1988, p. 1090). Bettes (1988) found, however, that depressed mothers often failed to make adjustments in their vocalisations in response to infant vocalisations, whereas non-depressed mothers made these adjustments consistently. Depressed mothers were also found to be less able to impose structures on their vocal behaviour – the average latency to respond to their infant for depressed mothers was nearly 2 seconds, and the length of their pauses and their utterances was highly variable. As Bettes (1988, p. 1095) points out, research suggests that the optimal interstimulus interval for infant conditioning is 1 second, and that pauses of longer than 3 seconds "indicate 'time-outs' or periods of disengagement".

In line with these findings, as Gelfand and Teti (1990, pp. 331-332) note, general (vocal and non-vocal) interactions between depressed mothers and their infants "have been observed to lack the sensitive reciprocity, synchronicity, and expressions of pleasure in each other's company often found in nondepressed mother-child pairs". A more recent study by Lundy (, 2002, cited in Lundy, 2003, p. 202) also shows that depressive symptoms in mothers "have been found to predict reductions in the frequency of parent-child synchrony".

Such 'asynchrony' also seems to continue beyond infancy into toddlerhood, with depressed mothers being less likely to repair interrupted interactions between themselves and their toddlers (Jameson, Gelfand, Kulesar & Teti, 1997, cited in Cicchetti & Toth, 1998). This study also found that the toddlers of depressed mothers were less likely to maintain interactions with their mothers and that depressed mothers and their toddlers showed less interactive coordination than non-depressed mothers and their toddlers.

As a recent review by Reck et al. (2004, p. 276) notes, overall depressed mothers are reported to "lack empathy and emotional availability", and to have "a reduced ability to perceive the child's signals and interpret them correctly, and to react appropriately and promptly". Depressed mothers have also been observed to show "a lesser degree of playful body contact as well as less loving interactions (kissing and stroking) with their infant" (Reck et al., 2004, p. 276).[19]

It should be noted at this point that the behaviour of depressed mothers is not homogenous with research identifying two main 'negative' interactional patterns between depressed mothers and their children, as well as a 'positive' interactional pattern, which is similar to the way in which non-depressed women interact with their children (see Field et al., 2001). The two main 'negative' patterns have been described as 'withdrawn, unavailable and understimulating' and 'hostile-intrusive and overstimulating'. Furthermore, some depressed mothers show a mixture of the 'withdrawn' and 'hostile' behaviours (Field, Healey, Goldstein, & Guthertz, 1990).

In light of the analysis being developed in this thesis it is very likely that such differing interactional styles may result in different clusters of suffering – some of which may be conceptualized as 'depression', others of which may not. For example, if a mother is profoundly withdrawn and disengaged this may interfere with the very basic processes involved in establishing a secure sense of 'mineness' or ipseity, suggested above to underlie the cluster of sufferings conceptualized as schizophrenia.

It should also be noted, however, that while depressed mothers can be 'withdrawn, unavailable and understimulating', the kind of profound disengagement which, it was suggested in Section 6.2, may contribute to the 'disturbances of self' that underlie 'schizophrenia' is not typical of depressed mothers[20]. Indeed, a wide-ranging meta-analysis of research concerning the parenting behaviour of depressed mothers by Lovejoy, Graczyk and O'Hare (Lovejoy, Graczyk, O'Hare, & Neuman, 2000, p. 583) suggested that depression seemed to be

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[19] It is acknowledged that the research concerning the interactions of depressed mothers with their children, like any research, will, to a certain degree, reflect the presuppositions and the values of the researchers. Nevertheless, the consistency of the findings (albeit couched in somewhat value-laden terms) and the compatibility of these findings with research which indicates that the children of depressed mothers are often later diagnosed as 'depressed' themselves, strongly suggests that the ways in which depressed mothers interact with their children may play a significant role in the genesis of 'depression'.

[20] Interestingly, a study by Goodman and Brumley (Goodman & Brumley, 1990) found that the parenting of 'depressed' women generally fell between that of 'schizophrenic' women and 'well' women, and that "depressed women's functioning was more variable than that of either other group" (Goodman & Brumley, 1990, p. 37). Furthermore, the results of this study suggested that the mother's diagnosis had its effect mainly via the 'quality' of her parenting and thus the model which emerged from these results "is that diagnosis influences the quality of the parenting and quality of parenting influences outcome" (Goodman & Brumley, 1990, p. 38)

> associated most strongly with irritability and hostility toward the child, to be associated to a somewhat lesser degree with disengagement from the child, and to have a relatively weak association with rates of play and other active and pleasant social interactions.

A review by Downey and Coyne (1990, p. 63) also highlights the high level of irritability and hostility evident in the interactions between depressed mothers and their children. As these authors point out, 'clinically depressed' mothers from the UCLA Family Stress Project were found to be "more irritable and critical and less positive and task focused than other mothers during a conflict resolution task with their child" (Downey & Coyne, 1990, p. 63) and that research also indicates that maternal depression predicts hostility towards children in a non-clinical sample.

Essentially, then, the research discussed above suggests that the behaviours characteristic of, though not confined to, depressed mothers, interfere with the ability of these mothers to achieve an attunement or synchrony between themselves and their infants. It has been suggested that such failures of attunement severely compromise the "particular form of pleasure upon which value [accorded to the self] depends" (Meares, 2000, p. 68). In light of the current analysis, then, if "the face and voice of the mother is where the baby's existence as the 'me' resides" (Meares, 2000, p. 85), then the emerging 'me' of the infants of depressed women is very likely to be a less responsive, less expressive, less happy 'me'; a possibility which the research seems to support.

A study by Cicchetti, Rogosch, Toth and Spagnola (1997), for example, which looked at children's affect displays upon recognizing themselves in a mirror, suggested that the children of depressed mothers begin to form negative feelings about their 'self' from very early in their lives. As these authors note, the development of what is called 'visual self-knowledge' (the ability to recognize oneself in the mirror) during early toddlerhood has been investigated empirically primarily through studies involving applying rouge to the nose of children, placing them in front of the mirror, and seeing if they then touch their own nose; if they do then this indicates that they can recognize themselves.

Research with 'low-risk' samples indicates that this visual self-recognition usually results in the display of 'positive affect' (e.g., Brookes-Gunn & Lewis, 1984 cited in Cicchetti et al., 1997, p. 342). Research with 'high risk' samples, however, shows a "higher level of neutral or negative affect accompanying self-recognition" {Schneider-Rosen & Cicchetti, 1984, 1991; Spiker & Ricks, 1984, cited in Cicchetti, Rogosch, Toth & Spagnola, 1997 , p. 341}.

Cicchetti et al. (1997) compared toddlers of depressed and non-depressed mothers and found that while there was no difference between the groups in the percentage of toddlers who showed the ability to recognise themselves in the mirror there were "striking affect differences" between the two groups of toddlers who had attained self-recognition; the self-recognizing toddlers of depressed mothers displayed "significantly more nonpositive affect while examining themselves in the mirror post-rouge application than did the toddlers who were self-recognizers in the nondepressed group" (Cicchetti et al., 1997, p. 356).

As Cicchetti et al. (1997, p. 356) note,

> what makes these data so compelling are that there were no differences between the two groups of self-recognizing toddlers during pre-rouge mirror inspection. Thus, the nonpositive affect exhibited during post-rouge application appears to have been associated with a self-evaluation process that resulted in the disruption of a positive affective display towards the self.

As Cicchetti, Rogosch, Toth and Spagnola (1997) also point out, research consistently suggests that the attribution patterns of depressed mothers seem to affect the types of self-attributions made by their children. For example, a study by Radke-Yarrow, Belmont, Nottelman and Bottomly (1990, cited in Cicchetti et al., 1997, p. 341) showed depressed mothers "conveyed significantly more negative affect in their attributions, particularly in regard to negative attributions about child emotions". Furthermore, among depressed mothers and their toddlers "there was a higher correspondence in the affective tone of attributions and statements about the self" (Cicchetti et al., 1997, p. 341). As Cicchetti et al. (1997, p. 341) note, "this finding suggests a heightened vulnerability among children of mood-disordered mothers for negative self-attributions".

Research also suggests that the infants of depressed mothers have problems with what is conceptualised in the literature as 'self-efficacy'. For example, the infants of depressed mothers have been found to make fewer efforts to activate their mothers and they "appear to lack initiative [and to] become withdrawn and querulous" (Papousek, 2001, cited in Reck, 2004). A study by Jennings and Abrew (2004) suggests that this lack of 'self-efficacy' continues into the toddler years, the age when children first start to develop a sense of themselves as a 'self', and to have ideas about the attributes of that 'self (conceptualised as 'self-concept'). In this study the toddlers of depressed mothers were less persistent, required more prompts and showed less pride and pleasure in their achievements than the toddlers of nondepressed mothers.

A study by Nolen-Hoeksema, Wolfson, Mumme and Guskin (1995) suggests that such problems with 'self-efficacy' may continue beyond the toddler years and into early and middle-childhood. The children of mothers "who were more negative and hostile and less able to encourage mastery in their children" were more likely to exhibit more helpless behaviours in a puzzle task and were "less likely to endorse active problem-solving approaches to frustrating situations" (Nolen-Hoeksema et al., 1995, p. 377). Furthermore, the teachers of these children rated them as "less competent and more prone to helpless behaviors" (Nolen-Hoeksema et al., 1995, p. 377).

'Self-efficacy' is a crucial aspect of a person's 'self-concept'; if one does not feel positive about one's agentic powers then this will inevitably affect the overall value one accords to one's 'self'. Of course our sense of ourselves as an agent in the world is, in Harré's (1998) schema, an aspect of 'Self 1', suggesting that the emergence of this aspect of 'self' of children who experience the kinds of early relational problems discussed above is also compromised. As was pointed out in Chapter Three, it is via our immersion in the various discourses that comprise our social world that we learn the various 'rules of engagement', and realise which rules are validated within which discourses. According to this view, right from the beginning our "intentions are structured by and emerge from the positions taken up in a social context and the discourses that pervade and structure it" (Harré & Gillett, 1994, p. 122)

For Harré and Gillett (1994) the validations operating within discursive contexts together with a person's 'self-location' or 'positioning' within these contexts emerge as the crucial factors influencing the attainment of a sense of control over one's actions in real-life situations. 'Validations' essentially provide people with options to look at a situation in one way rather than another and they also recommend commitments to certain positionings within a discourse. Thus, there will be certain 'options' within the discourses that surround us that are validated and others which are not.

For people who experience early relational difficulties of the kind typified by, but not confined to, the children of depressed women, it is suggested that the 'validations' operating within their discursive contexts would tend to constrain their options to look at situations, and to look at their own 'positioning' or 'efficacy' regarding those situations, in ways which would make the kind of 'helpless' behaviours outlined above much more likely. Furthermore, as was pointed out in Chapter Three (Section 3.3) such validations become, quite literally, embodied, an essential, albeit largely unacknowledged, aspect of one's personal being.

This does not necessarily mean that such a person would be 'helpless' in every situation. Indeed, there may be many situations within which, due to immersion in different 'discourses' as they grow up, they are able to exercise considerably more initiative and 'power' over their environment. It is suggested, however, that if the fragile 'self' of such a person was, at any stage threatened then feelings of 'helplessness' may well be re-activated. This is in line with the findings of the study by Treynor et al. (Treynor et al., 2003), cited above, which suggest that it is feelings of 'low-self mastery' that are most central to the experience of 'depression'.

Studies have also shown that the behaviour of infants of depressed mothers tends to be characterised by behaviours which 'mirror' the depressed behaviour of the mother such as "increased withdrawal and avoidance, avoidance of eye contact, a low level of expression of positive affect" (Reck et al., 2004, p. 276), more self-comforting behaviour (e.g., touching themselves or putting their fingers in their mouths) and less vocal utterances (Beebe, Lachmann & Jaffe, 1997, cited in Reck, 2004). And a study by Cohn, Matias, Tronick, Connell and Lyons-Ruth (1986) reported that in comparison to infants of nondepressed mothers, who are in 'Play' (during observed interactions with mothers) an average of 15 percent of the time, only one infant in the depressed mother group was in Play for this amount of time.

Furthermore, the results of a study by Field et al. (1988) suggests that the children of depressed mothers interact with strangers in much the same way as they interact with their mothers, although they did not look away from the strangers as frequently as they looked away from their mothers (Field et al., 1988). Field et al. (1988) suggest that gaze aversion may be 'stimulus-specific', in other words, it occurs as a direct reaction to the mother's unresponsiveness. Citing Tronic and Gianino (1986), Field et al. (1988) suggest that head and gaze aversion may be an attempt to "reduce the negative affect engendered by unresponsive maternal behavior" . . . [suggesting that] . . . the interactions with the stranger were not as stressful as those with their depressed mothers" (Field et al., 1988, p. 1575).

As was noted in Chapter Five, this kind of 'unsupportive' mothering, in addition to being stressful for the infant, also interferes with the child's ability to regulate its own emotional reactions, to 'self-soothe'. While babies begin to regulate their emotional responses very soon after birth by engaging in behaviours such as suckling to sooth themselves (Campos, 1988, cited in Repetti et al., 2002), a study by Van den Boom (1994, cited in Repetti et al., 2002, p. 345) showed that "parental nurturing appears to facilitate the development of these primitive coping behaviors". In this study an intervention

which improved "maternal responsiveness, attentiveness and control . . . resulted in an increase in infant self-soothing behaviors" (Repetti et al., 2002, p. 345). Further, infants whose mothers did not take part in this 'intervention' showed a slight decrease in self-soothing behaviours between 6 and 9 months and were rated as having "less secure attachment to their mothers".

The 'difficult' behaviours of the children of depressed women, including their lowered ability to 'self-soothe' and thus regulate their own emotional responses, would then, in turn, make it even more difficult for the already compromised mother-child relationship to function in ways that would overcome the effects of such 'dysregulations'. Within this 'negative cycle' the kinds of behaviours and feelings commonly observed in the children of 'depressed' mothers (although not confined to them) are likely to be experienced as aversive by the mother, further adding to her 'stress load' and potentially exacerbating her 'depression'. The mother's increasing depression would, in turn, lead to a progressive worsening of the already strained mother-child relationship. As Hammen, Burge and Stansbury (1990, p. 25) note, research suggests that the "negative, conflictual interactions" which characterise the interactions between depressed women and their children "are more likely to occur as the child's age increases".

If nothing occurs to break this cycle these difficulties will compound as these children grow older, leaving them less well equipped to deal with the challenges and complexities of the interpersonal relationships they will encounter in the wider social world. As Cicchetti and Toth (1998, p. 228) point out, for example, research has shown preschool-aged children of parents with a mood disorder "characteristically engage in uncontrolled and poorly regulated exchanges with peers" and that the boys of mothers who are depressed "have been found to generate aggressive strategies to solve hypothetical peer conflicts".

Cicchetti and Toth (1998, p. 229) further note that research has shown that younger children of depressed mothers tend to be 'over-aroused' to "hypothetical situations of interpersonal conflict and distress. This finding suggests that social difficulties may be more stressful to them than to children who have not experienced such early relational problems. Older children of depressed mothers, on the other hand, "appeared to struggle against experiencing guilt" and were also prone to being extremely sensitive, to the point of 'overinvolvement', to the problems of others (Cicchetti & Toth, 1998, p. 229).

Thus it is very likely a child who had experienced unsupportive parenting of the kind outlined above would experience more social difficulties, which themselves would be experienced as aversive and stressful at both the personal and the physiological levels. This may result in such children withdrawing from social situations and spending more time alone, thus lowering their chances of having positive social experiences which may, through assisting them to confer value upon the 'self', serve as a protection against 'depression'. As Gotlib and Hammen (1992, p. 53) note, research suggests that this might be the case, with studies which compared non-clinically depressed and nondepressed children finding that "the relatively depressed children rated others as less friendly in all social contexts, and indicated wanting to be alone more often, especially in the family context".

As was illustrated in Chapters Three and Five, a child's relationship with their first care-giver not only forges their person level feelings and their ways of being in the world, it also shapes their responses to the world at the molecular-organismic level. As the research outlined in Chapter Four made clear, if a child is involved in a relationship with a care-giver which is highly stressful or which is unable to buffer the child from the effects of other environmental stressors, this can adversely affect the reactivity of the child's HPA axis and leave the child less able to cope, at both the organismic-molecular and the person level, with the effects of stress.

As Essex, Klein, Cho & Kalin (2002, p. 777) point out, "numerous retrospective studies of adults and children suggest that increased reactivity of the HPA system is associated with early trauma and severe deprivation". Studies have also suggested less severe stress, such as that experienced due to unsupportive behaviours such as those shown by depressed mothers, is also positively associated with higher cortisol levels in infants and toddlers (Bugental et al., 2003; see Essex et al., 2002). Other studies with preschoolers and older children suggest that "children's cortisol levels are positively correlated with numerous concurrent stresses ranging from maternal depression and other social stresses to broader family characteristics known to be associated with higher stress levels" (e.g., low socioeconomic status) (Essex et al., 2002, p. 777).

In support of the contention that the ways in which depressed mothers interact with their children are stressful for the children, Field, Healy, Goldstein, Perry, Bendell, Schanberg, Zimmerman and Kuhn (1988) point out that elevated heart rate in infants has been noted in studies where the mother is asked to remain still-faced (Stoller & Field, 1982, cited in Field et al., 1988) or where the mother is 'over-stimulating' (Field, 1981, cited in Field et al., 1988) – both behaviours characteristic of depressed women.

Furthermore, Field et al.'s (1988, p. 1575) own study indicated that the infants of depressed mothers "showed higher heart rate and lower vagal tone when interacting with their mothers" in comparison to the infants of non-depressed mothers. The infants of depressed mothers also "showed higher cortisol values than the infants of nondepressed mothers" (Field et al., 1988, p. 1575).

Field et al. (1988) suggest that the infants' elevated heart rate during interactions with their depressed mothers may be due to the arousal of their sympathetic nervous system. Furthermore, the lower vagal tone of the infants during these interactions suggests a lowering of parasympathetic activity. As Field et al. (1988, p. 1577) point out,

> higher sympathetic arousal and, conversely, lower parasympathetic activity generally occur in stressful situations, suggesting that the infants of depressed mothers were stressed during their interactions with their mothers.

Interestingly, the heart rate of these infants was not elevated during their interactions with the stranger, despite their behaviour still remaining, with the exception of the amount of gaze aversion, much the same. This suggests that for these children interacting with their own mothers was more stressful than interacting with a stranger.

The elevated levels of cortisol in these infants is also indicative of the arousal of the sympathetic nervous system. As Field et al. (1988, p. 1577) point out,

> given the delay in the effects of stress on cortisol levels, and given that baseline measures of cortisol in infants are related to the levels of cortisol excreted under stress, it would appear that these infants may be experiencing chronic stress.

As has already been noted in Section 6.2, such 'dysregulations' of the stress response system are consistently reported in those diagnosed with 'affective disorders'. As Davidson (2002, p. 478) notes, elevated activity of the HPA axis "is one of the most replicated biological findings in major depression". This is in line with the suggestion that a general vulnerability to psychological suffering is conferred via early relational problems which causes 'damage' not only to a child's emerging personal being, but also to their developing neurobiological tools.

Thus, it is suggested that unsupportive parenting of the kind exemplified by, but not confined to, depressed women, damages not only the emerging 'self', but also the neurobiology that subserves that 'self', conferring upon the children of these women a particular vulnerability to the cluster of sufferings conceptualised as 'depression'. In order to experience an episode of 'depression', however, the person must also be placed

under stress of a sort which re-activates the aversive feelings which permeated their early life, stress which involves some sort of social loss, rejection or let-down.

In support of this contention, a wide-ranging review of the 'antecedents, concomitants and consequences' of depression by Barnett and Gotlib (1988, p. 119) concluded that depression is often preceded by the "disruption or loss of a central source of self-worth among individuals who do not have satisfying alternative sources of self-esteem" (Barnett & Gotlib, 1988, p. 119). This review suggests that "the disruption of a primary relationship, such as the marital relationship, may lead to depression" and that an "alienation within the individual's intimate interpersonal system may precede, and possibly precipitate, the onset of depressive symptoms" (Barnett & Gotlib, 1988, p. 120). As Barnett and Gotlib (1988, p. 119) note, such losses and alienations "most often involve important interpersonal relationships or social roles, but disappointments in the attainment of achievement related goals have also been recognized as precipitating events" (Barnett & Gotlib, 1988, p. 119).

This suggestion is supported by the research of Brown and his colleagues (Brown et al., 1986; Brown, Bifulco, & Andrews, 1990; Brown, Bifulco, Veiel et al., 1990) with the results of a study by Brown, Bifulco, Viel and Andrews (1990) showing that the "the ill-effects in terms of low self-esteem will on the whole not occur when the current environment is reasonably supportive". If the environment is unsupportive, however, depression is very likely to occur. For example, a prospective study by Brown, Andrews, Harris, Adler and Bridge (1986) found a very high rate of depression in women who confided in and were 'let-down' by partners or other people close to them. Conversely, for those who were not 'let-down', confiding in partners or other close sources of support, was associated with a low risk for depression.

Furthermore, in support of the contention that 'threats to self' are particularly likely to lead to 'depression' for people with a 'vulnerable self', studies carried out by Brown, Andrews, Harris, Adler and Bridge (1986) suggest that social support and NES (Negative Evaluation of Self) both contribute to the risk of depression. Furthermore, a study by Brown, Andrews and Bifulco (cited in Brown, Bifulco, Veiel et al., 1990) found that once a 'severe event' had occurred, NES "predicted an increased risk of depression at a caseness level" (Brown, Bifulco, Veiel et al., 1990, p. 225). The results of a study by Brown, Bifulco, Veiel and Andrews (1990) also made the link between NES and early relational problems, noting that when "early inadequate parenting and a negative current environment occur together, there is a potentiation of NES in a statistical sense

. . . That is, their combined presence is associated with an increased risk of NES" (Brown, Bifulco, Veiel et al., 1990, p. 231).

Further supporting the contention that events which constitute a 'threat to self' are very likely to trigger the feelings, and subsequently the thoughts, characteristic of 'depression', is the finding that many people experience their first episode of 'depression' during adolescence – a period of time marked by major role transitions and new, and potentially threatening, social experiences. A number of studies have found elevated rates of depressed moods in adolescence, as compared to adulthood (e.g., Allgood-Merten, Lewinsohn & Hops, 1990; Larsson & Melin, 1990, cited in Petersen, Compas, Brooks-Gunn, Stemmler, Ey & Grant, 1993). A general population study by Radloff (1991, cited in Petersen et al., 1993, p. 157) looking at incidence of 'depressed mood', for example, found "dramatic increases in depressed moods between the ages of 13 and 15 years, a peak at approximately 17-18 years, and a subsequent decline to adult levels".

Other studies have suggested that diagnoses of clinical depression also appear to increase dramatically in adolescence compared to childhood (Fleming & Offord, 1990; Rutter et al., 1976; Rutter, 1986, cited in Petersen et al., 1993). The period from late adolescence to the mid-20s, known as the 'transition to adulthood' is also "marked by high rates of major depression" (Reinherz, 2003, p. 2141).

The initial impact of a social exit or role loss which threatens the 'self', it is suggested, will be to reactivate 'somatic markers' or embodied memories of highly aversive childhood experiences – experiences, as already noted above, that are marked by a profound sense of 'misattunement' with the world (experienced in early infancy as the mother) and permeated with what Meares (2000) refers to as 'disjunctional anxiety'. At the organismic/molecular level, the reactivation of such 'memories' would initiate the body's stress response systems (Schwarz, 1994), already sensitized due to stress-induced vulnerability of limbic areas (Post, 1992; Post, Weiss & Leverich, 1994, cited in Harkness & Tucker (2000) resulting in either emotional hyperreactivity (quick to cry, irritable, prone to tantrums), or emotional hyporeactivity (social withdrawal, emotional flatness, apathy, disinterest in surroundings) (Schwarz & Perry, 1994).

Thus, the physiological stress induced by the social exit or role loss would manifest itself as person-level feelings and behaviours such as tearfulness, anxiety, irritability, insomnia (or hypersomnia) and agitation (or lethargy) – all of which are 'symptoms' of 'depression' according to the DSM-IV-TR (American Psychiatric

Association, 2000). These behaviours and feelings, along with a profound sense of 'misattunement' or 'asynchrony' reactivated by the perceived threat to the self, would, it is suggested, be very likely to be the first 'signs' that something was wrong with the negative thoughts and feelings about the 'self' coming later, as people utilise their 'inner voice' to respond to, and as an attempt to 'make sense of', these feelings (Cromby, 2006b).

While there is not a lot of research into people's subjective experience of the early stages of depression, a series of in-depth interviews with people who had suffered recurrent episodes of 'depression' by Hagerty, Williams & Liken (1997) provides research support for the suggestion that the feelings (rather than the thoughts) come first. As these authors point out, early 'signs' that depression was imminent for the participants in this study tended to be a vague sense that 'something wasn't right', often experienced as 'stress' or 'anxiety' and often attributed to external causes such as work stress or lack of sleep.

> My acceptance of the illness followed several months of denial during which, at first, I had ascribed the malaise and restlessness and sudden fits of anxiety to withdrawal from alcohol; I had abruptly abandoned whisky and all other intoxicants in June.
>
> William (Styron, 1990, p. 8)

The next stage of the 'depressive prodrome', these authors suggest, includes alterations in sleep and appetite, lack of energy, changes in the way they are thinking, withdrawal and isolation and general anxiety.

> It was not really alarming at first, since the change was subtle, but I did notice that my surroundings took on a different tone at certain times: the shadows of nightfall seemed more sombre, my mornings were less buoyant, walks in the woods became less zestful, and there was a moment during my working hours in the late afternoon when a kind of panic and anxiety overtook me, just for a few minutes, accompanied by a visceral queasiness – such a seizure was at least slightly alarming, after all.
>
> William (Styron, 1990, p. 42)

Interestingly, and in line with the analysis being developed in this thesis, Hagerty, Williams and Liken (1997, p. 310) suggest that these symptoms "were all linked to one general outcome, the inability to experience congruence, harmony, or synchrony with the environment", a feeling of being 'out of tune' with other people, and with the world in general. Such feelings, it is suggested, may be reactivated memories of the profound sense of 'misattunement' or 'asynchrony' experienced by the person during their very early interactions with their first care-giver.

These authors labelled this experience as 'desynchrony' and noted that it was "disturbing to all participants" (Hagerty et al., 1997).

> Everyone else seemed to be moving through their days peacefully, laughing and having fun. I resented them because they were experiencing such an easy time of it. I felt utterly cut off from them emotionally. I was angry because there was no way they could understand what I was going through. Their very presence seemed to magnify my sense of isolation.
>
> David (Karp, 1996)

> Oh, I was so alone. I played basketball. I was a member of a team. I had a roommate, but I was so alone. I had a lot of friends, but I was completely isolated. And that's what, like, I believe depression is – a disease of isolation that tells you to withdraw, stay away, don't be a social person. Stay away from the people who are going to make you better. Yeah, the need to be alone, to withdraw. That's one symptom. But I was like, just so alone. I can remember walking around, walking around in the rain one day, just like "What the hell? What was wrong with me? What is wrong with me?".
>
> Male salesman (Karp, 1996, p. 37)

For the participants in Hagerty et al.'s (Hagerty et al., 1997) study such feelings often led to avoidance of interpersonal interactions.

> I cut myself off from the world and my friends. Two years of my life disappeared into a black hole.
>
> Kathryn (McNeil, 1993, p. 13)

> I would just withdraw from people and places and things that were going on around me. I would end up just sitting in front of a TV or sitting at home in bed . . . I just got to the point where I just wanted to be alone and withdrawn from other people. All I can say is that I would find myself uncomfortable being with other people
>
> Male Office clerk, part-time (Karp, 1996, p. 36)

> In my *crise a quarante ans* I shrank from all human relations, and this explained the image Paul Rosenfeld happened upon in the fine essay he wrote about me. He spoke of a house with the shades drawn and a man sitting within, a man who could not hear the knock when life drove up to the door with her merry summons. How could Paul ever have guessed what was happening in that house?
>
> (Brooks, 1964, p. 84)

This disturbing experience of desynchrony and the social withdrawal it precipitated, was then followed by the occurrence of the 'symptoms' which signalled the

beginning of an acute episode of 'depression' to all participants, a point which Hagerty et al. (1997) labelled as 'the crash'. It was at this point, according to Hagerty (1997) that the participants in his study started to notice changes in 'cognition', in other words people start to 'notice' they are thinking differently and these 'different thoughts', as research consistently indicates, are "dominated by a negative view of the self, the world and the future" (Beck, 1976, cited in Bentall, 2004, p. 239). Beck (1976, cited in Bentall, 2004) notes that "automatic or unbidden thoughts that reflect these [negative] themes are the immediate precursors of a dysphoric mood" (Bentall, 2004, p. 239).

As was noted above, such negative thoughts and feelings about the 'self' are essentially people's attempts to respond to, and to 'make sense of', the profoundly aversive feelings which begin to permeate their experience of life following the 'threat to self'. Essentially, as Cromby (Cromby, 2006b, p. 14) sees it, things happen which evoke feelings and we name these feelings with inner speech. This inner speech can then evoke more feelings, which in turn will lead to further commentary, and more feelings, and so it goes on. It should also be noted at this point that because the capacity for 'inner speech' also emerges from people's early experiences with their first care-givers, as was outlined in Chapter Three , it is very like that the 'inner voice' of those who have experienced early relational difficulties will find 'negative ruminations' particularly easy and familiar.

As Cromby (2006b, p. 14) notes, "there is a constant iteration between socialised feelings and socially derived inner speech, a dialectical relationship, a ceaseless flux of fluid movment from one to the other". It is at this point that people are most likely to articulate extremely negative feelings about the 'self', feelings of failure and shame at their incompetence, as writer Van Wyck Brooks (1964, pp. 83-84) describes;

> There came a time in the middle twenties when my own bubble burst, when the dome under which I had lived crumbled into ruin, when I was consumed with a sense of failure, a feeling that my work had all gone wrong and that I was mistaken in all I had said or thought. What had I been doing? I had only ploughed the sea, as a certain great man once remarked, and I thought of my writing "with rage and shame", E.M. Forster's phrase for his own feeling about his early work.

Such ruminations can then, in turn, exacerbate the feelings and contribute to the downward spiral so characteristic of 'depression'.

> . . . after a while it takes on a life of its own. You don't have any control [over] your thinking or how despairing you feel or how morose you start feeling. It just takes off.

> And you need some intervention or some relief because you can't deal with the pain anymore
>
> Unemployed, disabled female (Karp, 1996, p. 32)

> What happens [is] my head, I feel kind of light-headed, and it just kind of shuts off. And it can be very frustrating, especially if you're working and trying to do something. The whole head, it's just . . . awful. What happens [is] I can tell when I'm starting to get depressed. When I begin to have some depression [I begin to have] dark thoughts, something bad is going to happen . . . You're going to die. It doesn't matter how type of thing, you know. Isn't it sad that you're going to, you know, take over, and then the anxiety, light-headed, don't feel like eating. These are all symptoms . . . But when those initial thoughts start to come in regularly, they basically take over. Then it's like life is worthless, and why even bother to get out of bed.
>
> Male salesman (Karp, 1996, p. 31)

Thus, while it is being suggested that the vulnerable or devalued self lies at the centre of the cluster of sufferings conceptualised as depression, and provides it with its person-level particularities the subjective experience of this devalued or 'non-self' involves considerably more than just 'negative cognitions about the self' or 'low self-esteem'. Such assessments of the 'self', it is suggested, are 'after the fact'. They are, as has been pointed out above, simply the attempts of the person to 'make sense of', to 'give voice to', the intensely negative feelings aroused in them, at every level of their being, by events which re-awaken embodied memories of being profoundly 'out of tune' or 'out of step' with their world (as originally represented by their primary care-giver), a sense of being essentially 'unre-cognised', as Meares (2000) puts it. This sense often manifests itself in particularly severe experiences of depression, in feelings of being a non-self, or of not existing at all in relation to other people.

This is reflected in the comments of a woman with recurrent depressions who had eventually sought ECT treatment as a last resort;

> I use the words 'my' and 'I' as a convention, actually, whatever constitutes a self is absent. Although everything is frightening, nothing matters – there is no 'me' for it to matter to.
>
> (Anonymous, 2006, p. D1)

> [Depression] is a black hole – a profound disconnection between the self and the life force.
>
> (Anonymous, 2006)

Once caught in this 'vortex' of feelings and thoughts people begin to experience the kind of anguish and despair that moves out of the realm of understandable and into the realm of the 'ununderstandable'.

> I would say it kind of feels like somebody is holding a match that's lit and just the flame is really hot and you're trying to stand it, and it's just consuming you more and more and then it just gets down to the end and there's no more, and the consuming part is just complete hopelessness. You start off as a whole person and then little by little things that you care about start floating away and they're not important any more and they get harder to hold on to. They just become less and less important and harder to try and do and the easiest thing to do is just to lie down and let it consume you.
>
> Female nanny (Karp, 1996, p. 29)

> I mean it's doom, it's hopelessness, down the water is death, and up is just a dark storm that you want to get away from, but can't . . . That's why the sense of doom. And that causes a paralysis, you know . . . The sense of doom actually paralyzes you . . . It incapacitates you . . .
>
> Male custodian (Karp, 1996)

> There's a real strong element of despair [to depression]. I mean it was like so overwhelming that [despair] was all I felt. And . . . when I got myself admitted [to the hospital] this last time I just had this incredible sense of despair [with] no end to it. You know, just a constant ocean of it . . . Also, after a while it takes on a life of its own. You don't have any control [over] your thinking or how despairing you feel or how morose you start feeling. It just takes off. And you need some intervention or some relief because you can't deal with the pain anymore
>
> Unemployed, disabled female (Karp, 1996)

For some people their pain reaches a point where they feel, quite simply, unable to go on and they begin to fantasise about death. These 'fantasies' are, in the same way as the 'ruminations' discussed above, attempts on the part of the person to make sense of, or to alleviate, their feelings. Unfortunately such thoughts tend to result in an exacerbation of the pain, creating a downward spiral that, for some people, can end in suicide.

> What I had begun to discover is that, mysteriously and in ways that are totally remote from normal experience, the gray drizzle of horror induced by depression takes on the quality of physical pain. But it is not an immediately identifiable pain, like that of a broken limb. It may be more accurate to say that despair, owing to some evil trick played upon the sick brain by the inhabiting psyche, comes to resemble the diabolical discomfort of being imprisoned in a fiercely over-heated room. And because no breeze stirs this

> caldron, because there is no escape from this smothering confinement, it is entirely natural that the victim begins to think ceaselessly of oblivion.
>
> (Styron, 1990, p. 50)

> I was possessed now with a fantasy of suicide that filled my mind as the full moon fills the sky. It was a fixed idea. I could not expel this fantasy that shimmered in my brain and I saw every knife as something with which to cut one's throat and every high building as something to jump from. A belt was a garrotte for me, a rope existed to hang oneself with, the top of a door was merely a bracket for the rope, every rusty musket had its predestined use for me and every tomb in a graveyard was a place to starve in.
>
> Van Wyck (Brooks, 1964, p. 84)

> Sometimes I fear for my own safety, and have frightening visions of hurting myself. I have considered suicide, and planned how I would do it down to the last detail. I used to have hideous nightmares that I was dead.
>
> Kathryn (McNeil, 1993, p. 13)

Central to these quotations is the notion that such 'fantasies' occur 'against one's will'. One's 'self' is no longer in charge, it is in too much pain. There is a sense of watching oneself moving inexorably, and almost unwillingly, towards destruction, eloquently described in this quote from William Styron's (1990, p. 50) *Darkness Visible*;

> A phenomenon that a number of people have noted while in deep depression is the sense of being accompanied by a second self – a wraithlike observer who, not sharing the dementia of his double, is able to watch with dispassionate curiosity as his companion struggles against the oncoming disaster, or decides to embrace it. There is a theatrical quality about all this, and during the next several days, as I went about stolidly preparing for extinction, I couldn't shake off a sense of melodrama – a melodrama in which I, the victim to be of self-murder, was both the solitary actor and lone member of the audience. I had not yet chosen the mode of my departure, but I knew that that step would come next, and soon, as inescapable as nightfall.
>
> (Styron, 1990, pp. 64-65)

It is suggested that seriously contemplating, or actually committing, suicide would be much more likely for those who experienced particularly severe early relational difficulties, and whose sense of 'self' was, consequently, particularly vulnerable. This is supported by the results of a study by Felitti (2002) whereby the 'adverse events' (e.g., parental violence, childhood sexual abuse, parental alcoholism) of a person's life were counted and they were given a score between 1 and 10. An individual with an ACE score of 4 or more was not only 460% more likely to be suffering from 'depression', they were also 1,200% more likely to attempt suicide. Indeed, Felitti

(2002) suggests that about two-thirds to 80 percent of all attempted suicides could be attributed to adverse childhood experiences.

It is suggested, however, as it was for 'schizophrenia', that extreme adversity (such as childhood sexual or physical abuse) in and of itself is not foundational of the particularities of the 'depressive' experience. If such abuse occurred within the context of the kind of unsupportive parenting outlined above, and was perpetrated by someone close to the child on a frequent basis, however, it would be very likely to exacerbate the vulnerability of the emerging 'self' and thus would contribute to the severity and chronicity of their eventual 'depression'. This contention is supported by research which shows that childhood adversities, including emotional abuse, physical abuse or sexual abuse, are commonly found in people who are 'clinically depressed' (Felitti, 2002; Molnar et al., 2001) and that such adversity is associated with more severe 'symptomatology' (K. L. Harkness & Monroe, 2002) and with earlier onset (Young, Abelson, Curtis, & Nesse, 1997).

For the vast majority of people, however, the 'option' of ending it all, while it may be contemplated in some cases, is ultimately discarded. Indeed, as Richards and Perri (2002) point out, for adults, the typical episode of depression lasts between 12 and 20 weeks with about 80 percent of all depressed people 'recovering' within a year. Such 'recoveries' are sometimes achieved with professional help, but are often achieved without it (Richards & Perri, 2002). Such 'recoveries' are frequently accompanied by positive changes in the person's social environment, either serendipitous or purposely arranged, and by active efforts on the part of the previously depressed person to reduce the amount of stress they are under (Richards & Perri, 2002).

Nevertheless, these 'recoveries' are only temporary for most people, with 80-85 percent of formerly depressed people 'relapsing' several times over the course of their life (Kessler & Magee, 1995, p. 197; Richards & Perri, 2002). This is not surprising in light of the analysis being developed in this thesis. As has already been noted, the feelings which arise as a consequence of the kind of early relational problems suggested to underlie the 'vulnerable self' are an integral part of one's personal being. They are there from the beginning and they remain at the core of our experience throughout our lives.

If that 'vulnerable self' is threatened again then those feelings will be very likely to be activated again, even if the person has already been 'cured' of a previous depression. This is particularly likely due to the inability of most commonly utilised therapies (e.g., cognitive-behavioural therapy and pharmacotherapy) to address the

embodied feelings/memories that lie at the root of 'depression'. Indeed, having already experienced a 'depression' will make it all the more likely the person will experience another one in reaction to a similar threat. As Hagerty et al. (1997) point out, clinicians treat more patients for recurrent than first-time episodes and recurrence is also associated with increased severity and increased duration of episodes, and shorter periods of wellness between episodes (Hagerty et al., 1997). As with all other things we 'do' in our lives, if we have 'done' depression once, we will find it easier to 'do' it again.

Thus, for the person with the kind of early relational difficulties outlined in this section, every threat to the vulnerable self, even if these threats seem quite minor to an outsider, has the potential to reactivate the embodied feelings that permeated their earliest interactions with their care-giver. These feelings would then suffuse their current experience and impact on their being at every level, from the molecular to the personal and the whole process would begin all over again.

6.4. CONCLUSION

The analyses presented in this chapter utilised the basic approach outlined in Chapter Five to attempt to build an alternative understanding of how the clusters of suffering conceptualised as 'schizophrenia' and 'depression' may emerge from within the complex coactions between all the aspects of a child's being– molecular, organismic and personal – and their social world. The central focus of these analyses was on how the particularities of the relationship between a child and their mother may shape the emergence of differing 'senses of self' (Harré, 1998), and how these 'senses of self' in turn, given certain environmental contingencies, shape the particularities of the sufferings that the child later experiences.

Thus, the analysis presented in this thesis, in agreement with many authors whose work I draw on, suggests that there is no one 'cause', in a straight-forward linear-causal sense, for psychological suffering. As was noted in Chapter Five, no factor, not even one so fundamental as the early relationship between a child and its primary care-giver, can ever entirely determine an outcome in a dynamic system such as a human being. Early relational problems may 'plant the seeds', but such suffering requires fertile ground within which to grow.

In this chapter some of the more proximal factors suggested to be necessary, although not sufficient, to the emergence of the particular clusters of suffering conceptualised as 'schizophrenia' and 'depression', were discussed. In this final section I will briefly outline some more distal factors that also contribute towards the precipitation and maintenance of psychological suffering. While such factors have not been the focus of the analysis developed in this thesis, as has already been indicated several times it is impossible to reach any useful understanding of psychological suffering without placing it within a wider socio-cultural context.

First, as was discussed in Chapter Five, it is very likely that, for a number of complex reasons, the vast majority of humans in modern setting have experienced early relational experiences that were not ideal for the kinds of animals we are, thus contributing to a generalised vulnerability to the ever-increasing list of 'mental disorders' endemic to, and rapidly increasing in, Western and Westernising societies [21] (Good & Kleinman, 1985; Schumaker, 2001; Seligman, 1990). The kind of damage suggested to be necessary for the emergence of 'schizophrenia' and 'depression' may not occur some cultures due to child-rearing being a more communal affair. In such societies considerably less pressure is placed on the mother to be all things to her child, and children are more likely to be enmeshed in a social network of people who are able to care for them if their mother cannot.

Furthermore, it is suggested that the kinds of 'social stressors' and 'threats to self' necessary to the precipitation and maintenance of the kinds of sufferings conceptualised as 'schizophrenia' and 'depression' would be much more likely to occur within a modern Western society than they would within a more sociocentric society. As Schumaker (2001, p. 3) points out, Western modernity has "high degrees of structural-functional differentiation, as well as unprecedented social mobilization that operates in conjunction with liberal capitalism". This results, suggests Schumaker (2001, p. 3) in

> the subordination of social, economic, and political values to the logic of the market. The values of personal autonomy have risen to ascendancy in an increasingly hyperglobalized environment that ushers in a type of consciousness that diminishes prospects for solidarity.

[21] It is suggested that because both the social constructionist analysis and the developmental approach to biology outlined in Chapters Three and Four of this thesis imply the centrality of the coactions between the organism/person and the wider world (both material and, most importantly, social) through their emphases on openness of the constitutive processes, broadening the analysis to include more distal or macro-social factors represents a 'natural' theoretical progression.

This would not be a problem, of course, if humans were endlessly flexible beings, essentially unhitched from their biological bodies and their basic and indisputable need – at every level of their being – for social connections with other human beings (Blaffer Hrdy, 1999; Schumaker, 2001; Small, 1998; S. E. Taylor, 2002) (Hofer, 1987; Hofer, 1984). As Schumaker (2001, p. 7) points out, however,

> [a]loneness and social alienation are intolerable states for the human being. We would whither and die, both psychologically and physically, if deprived entirely of the opportunity to relate meaningfully to other people.

The threat, and in many cases the reality, of such deprivation, however, particularly during early development, is a common feature of the modern Western existence. As Schumaker (2001, pp. 121-22, author's italics) points out, "mental health professionals now speak of the problem of *existential isolation* that affects many people today". Yalom (cited in Schumaker, 2001, p. 122) defines this as "a separation between the individual and the world" and it is experienced as "deep loneliness and a vague all-pervasive misgiving". It is perhaps not surprising, then, that rates of 'mental disorder' are so high in the West, given that the factors that precipitate and maintain such distress are particularly prevalent in comparison to less 'modern' societies.

This may, at least partially, explain the consistent finding that schizophrenia is far more common in urban environments (Mortensen et al., 1999; van Os, Hanssen, Bijl, & Vollebergh, 2001). Indeed, a study by Mortensen et al. (1999) suggested that urban birth alone may account for 34.6% of the cases of schizophrenia on a population basis. Furthermore, another study by the same team of researchers (Pedersen & Mortensen, 2001, cited in Bentall, 2004, p. 477) found a

> dose-response relationship between exposure to an urban environment in childhood and the development of psychosis in later life. It seems that the greater proportion of childhood spent living in urban environments the greater the risk of madness, with those who spend their entire childhood in cities being most at risk in later life.

While such findings are often interpreted to be due to increased exposure to viruses or other biological factors, researcher Jim van Os (cited in Velasquez-Manoff, 2005) suggests that the risk factors posed by the urban environment must be social in nature. As van Os (cited in Velasquez-Manoff, 2005, p. 2) points out, "studies of smaller communities show a correlation between social fragmentation, isolation, inequality and an increased risk of psychosis".

Furthermore, as has been noted in Chapter Five, the private, autonomous and individualised 'self' that emerges out of the typical Western upbringing also makes it more likely that a person will be vulnerable to experiencing such social isolation and alienation (Shweder & Bourne, 1984). This may occur not only because of a person's own prioritisation of individualistic needs (e.g., success, money, pleasure) over relational needs, but also because many others in the person's social world will be prioritising *their* individual needs also.

The Western view of 'self' also makes it much less likely that people will be able to locate the source of our problems, or indeed of their very motivations and intentions, outside of their 'selves'. This, in turn, makes it more likely that they will blame themselves for their problems. Indeed, there are a number of discourses in the West around 'personal responsibility' that overtly encourage this, thus providing fertile soil for the 'negative attributions', 'low self-esteem', and feelings of guilt which are so central to many 'mental disorders' in the West (Schumaker, 2001). If something goes wrong, or our life is not working out as we planned, we have no-one to blame but ourselves.

As Schumaker (2001, pp. 62-63) notes,

> the individuated self personalizes the inner states of emotion and is easily overwhelmed by adversity and difficult life events. The results are self-blame, isolation, loneliness, guilt, existential despair and other symptoms that manifest themselves in the Western brand of depression.

Schumaker (2001, p. 63) suggests that the unindividuated self is "better able to locate problems at a less personal level", and thus avoids the emotional brunt of these problems by being able to place stressful life events "within the wider context of a collective identity". This is in line with research which shows that "the 'cognitive symptoms [of depression] – especially guilt and low self-esteem – are less evident in developing countries than in the West" (Bentall, 2004, p. 236).

As was also noted in Chapter Five, the Western conceptualisation of 'self' would also make many of the feelings/experiences involved in the cluster of sufferings conceptualised as 'depression' and 'schizophrenia' much more threatening and thus anxiety inducing, than people with a more 'un-individuated' (Shweder & Bourne, 1984) self. As was pointed out in Chapter Five, "'dysphoria' – sadness, hopelessness, unhappiness, lack of pleasure with the things of the world and with social relationships – has dramatically different meaning and form of expression in different societies" (Kleinman & Good, 1985, p. 3). Indeed, in some cultures such experiences are viewed as

being positive, rather than negative, healthy rather than pathological, making it very unlikely that they would precipitate the particular 'cluster of suffering' conceptualised as 'depression' in the West.

Furthermore, while for Westerners the sense that one's 'self' is 'dissolving' or 'fragmenting' or that one is 'losing oneself' is profoundly threatening, it is possible it would not be experienced as so threatening in the context of a more 'sociocentric' (Shweder & Bourne, 1984) culture. Indeed, it is possible that the conceptualisation of the 'self' in more sociocentric cultures is so profoundly different to that of individualistic societies, that there is no 'self'[22], in the Western sense, to 'dissolve' or 'fragment'. If these 'anomalies of experience', as Parnas and colleagues call them, were not seen as threatening then they would not induce the kind of anxiety they do in Western contexts, and may, in some instances, be experienced as a state of being which was simply 'different', rather than profoundly distressing. The same point may be made about many of the other 'symptoms' of 'schizophrenia' such has hallucinations, a sense of being somehow separate from one's body, unusual bodily sensations etc.

Finally, modern Western societies are also less likely to provide the kind of environment within which 'recovery' from the kinds of psychological suffering conceptualised as 'mental disorder' is optimised or even, in many cases, possible. The consistent finding that the prognosis for 'schizophrenia' is considerably better in non-Western, non-industrialised societies supports this suggestion. This may be due to a number of factors, including the possibility that a less individuated 'self' may be protective against the kinds of 'disturbances of self' thought to underlie 'schizophrenia', that some of the experiences which are considered to be 'symptomatic' of 'schizophrenia' may not be considered to be problematic or pathological, and the fact that many people who are diagnosed with 'schizophrenia' in the West become extremely isolated from their fellow human beings.

As Warner (1985, p. 172) points out, being a 'schizophrenic' in a Western industrial society is, for many people, "an unbelievably bitter experience". As Warner (Warner, 1985) points out, roughly half of New York City's homeless are 'mentally ill' in one way or another and between 6 to 8 percent of the inmates of local jails in the United States are psychotic. Furthermore, Warner (1985, p. 186) notes that even if they are not on 'skid row' or in jail, "Western schizophrenics lead lives of social isolation". Schizophrenics have been found to have close contacts with far fewer people than

[22] At least in the sense of 'Self 2' – one's sense of oneself as a relatively coherent and unitary 'self' – and 'Self 3' (the presentation of that 'self' to others).

'normals' and a third of those considered 'chronically mentally ill' have no friends at all (Warner, 1985).

That isolation, like the anxiety discussed above, compounds the already existing problem. We need other selves around us in order to be ourselves throughout our lives, not just at the beginning. Even for a 'normal' person, maintaining the sense of oneself as a coherent unity[23] in the face of the kind of isolation endured by people who have been diagnosed 'schizophrenic' in the West would be very difficult. For someone with 'schizophrenia', who faces the task of not only maintaining but of actually attempting to reconstruct some sort of semblance of 'self', such isolation would make this task all but impossible.

[23] As noted above this is central aspect of the Western sense of 'self'.

CONCLUSION

TOWARDS A NEW UNDERSTANDING OF PSYCHOLOGICAL SUFFERING

It was suggested in the Introduction to this thesis that the lack of progress made towards understanding and preventing, or, in many cases, even alleviating, psychological suffering has been due, in large part, to the way in which such suffering is conceptualised – as s 'disorder', 'illness' or 'disease' which is located, and is thus potentially locatable, within the individual. This conceptualisation of psychological suffering was referred to as the 'Dysfunctional Mind Account' (DMA), and in Chapter One it was argued that this conceptualisation underlies all accepted models or theories of psychological suffering and is the dominant way of conceptualising such suffering for both professionals and lay-people in Western cultures.

It was argued in Chapter Two that this conceptualisation is inherently flawed at a theoretical level, and has very little empirical support. It was further suggested that, at a practical level, such a conceptualisation leads to the search for both causes and 'cure' being focused primarily 'inside the skin' of the individual; a partial approach which leads to only partial and often misleading results. This approach not only compromises our understanding of such suffering, but also compromises our efforts to prevent and to 'cure' and/or alleviate such suffering. In the Concluding section of Chapter Two, it was argued that the main reason the DMA is unable to assist us in understanding and alleviating psychological suffering is because it is underpinned with assumptions about human beings and their suffering which are inherently faulty.

These assumptions are as follows –

1) that certain activities or experiences of persons (those referred to as 'mental' or 'psychological' and which are seen as occurring 'inside' the person, e.g., thoughts, beliefs, wishes, fears, hopes, etc.) are seen as

representing or occurring in something called the 'mind', an entity posited to contain, or comprise, these activities and experiences;

2) that this 'mind' can then be investigated by science, a position that has made it easy to conflate the 'mind' with the brain;
3) that particular sorts of psychological suffering (and ideas about which sorts can change according to the time and the place where such decisions are being made) are indicative of a 'dysfunctional mind' (or brain)
4) that humans are autonomous individuals, essentially separate from each other, and from 'society', and that society is simply a backdrop to human life.

In the Introduction to Chapter Three an approach to understanding human experience was presented which overturns these assumptions, and in so doing overturns the notion of the "atomistic, bounded, coherent, rational psychological subject endorsed, at least implicitly, by most mainstream approaches" (Cromby, 2004a, p. 797). As Handy (1987, p. 163) points out, one of the most fundamental propositions of this approach, which is referred to as 'social constructionism', is that

> human subjectivity and action are so inextricably interwoven with the social context which people inhabit that a theoretical separation between the individual and society is conceptually inadequate.

Because of this the social constructionist approach necessitates

> developing analyses which acknowledge firstly, that human subjectivity and actions are constituted within and through social structures, and, secondly, that people are also the producers of the social structures they inhabit.
>
> (Handy, 1987, p 164)

The account presented in Chapter Three attempted to sketch out such an analysis, drawing primarily on the theorising of Rom Harré, John Shotter and John Cromby. The work of these theorists, it was suggested, was particularly useful for seeking an alternative understanding of psychological suffering because of their focus on the social construction of our subjectivity, our experience of being persons in the world; our 'personal being' as Harré (1984a) refers to it. It is at this person-in-the-world level (rather than at the organismic or sub-organismic level) that the kinds of suffering conceptualised as 'mental disorder' are primarily experienced, indeed it is this that sets them apart as 'mental' and provides the justification for a separate (albeit medical) speciality devoted to them. If they manifested themselves purely, or primarily, at a physical level they would not be 'mental disorders'.

As was pointed out in Chapter Three, for Shotter and Harré our individual, unique mental lives are essentially social productions. Indeed, Harré (1984) characterises them as being the result of the acquisition of a theory rather than of biological maturation and suggests that most of the things we take to be "metaphysically ultimate in psychology are referents of theoretical concepts" (1984, p. 21). As Harré (1984, p. 20) notes,

> [a] person is not natural object, but a cultural artefact. A person is a being who has learned a theory, in terms of which his or her experience is ordered.

Both Harré (1984a; 1998) and Shotter (1974a; 1974b; 1984; 1997) suggest that this 'theory learning' process occurs within the context of an infants' earliest social relationships, and, in particular, their relationship with their mother. As Harré (1984, pp. 21-22) notes, from the very beginning "infants make demands upon their mothers and other caretakers that provoke the very talk and action from the mother" that facilitates the development of personal being – a being with a sense of oneself as a singular being with a continuous and unique history with a capacity for self-reference ('self' consciousness), and a sense of oneself as an agent – "a being in possession of an ultimate power of decision and action" (Harré, 1984, p. 29).

It was suggested that if our 'personal being' emerges from our enmeshment with our social world, then it is likely that the kinds of suffering conceptualised as 'mental illness' may also emerge, at least in part, from the particularities of that enmeshment. It was further suggested that if we could understand the processes involved in the emergence of our 'personal being' it is possible we may be able to come closer to some understanding of why the various problems we call 'mental illness' occur and begin to move towards a way of conceptualising such suffering that does not frame such experiences as 'illness' or 'dysfunction' but, rather, sees them as emerging from the intricate coactions between the person and the social world within which they must live their lives.

In Chapter Four, however, it was acknowledged that the emergence of persons and their psychological suffering cannot be understood by looking only at sociocultural and discursive factors because persons are both socioculturally *and* biologically co-constituted. In order to facilitate a clearer articulation of the ways in which this co-constitutional process occurs, a brief outline of the developmental approach to biology taken by Steven Rose (1997) was provided before discussing some recent research from the biological sciences which illustrates Rose's (1997) central contention – that the lifeline of an organism is constructed via its enmeshment in its environment, and thus cannot be

understood without taking that environment into account – an insight which mirrors the social constructionist position that a person cannot be understood separately from the social world within which s/he is enmeshed.

At this point the scene was set to embark upon the task, in Chapter Five, of outlining how our personal being is biologically and socioculturally co-constituted and how vulnerabilities for the kinds of psychological suffering conceptualised as 'mental disorder' may emerge from such processes. This outline served as a general template for more detailed analyses presented in Chapter Six, of how, depending on the vagaries of each person's particular life trajectory, different kinds of psychological suffering – those clusters of suffering conceptualised as 'schizophrenia' and 'depression' – may emerge.

It is acknowledged that there have been a number of attempts, particularly within the field of developmental psychopathology, to generate alternative understandings of psychological suffering wherein such suffering is conceptualised as emerging from the coactions that occur between the various levels of our being in this world and the environment within which we are enmeshed. It is suggested, however, that such accounts, while offering considerably more insight into psychological suffering than accounts that do not acknowledge such complexity, are nevertheless still underpinned by the same assumptions which underlie the Dysfunctional Mind Account.

As was pointed out in Chapter Two, 'biopsychosocial' accounts still see the human being as being essentially a composite of parts that are separable by science; the 'mind' and the body, emotions and cognitions, rationality and irrationality, actions and thoughts. Such accounts also see the human being as separable from the social and material environment with the environment merely 'impacting upon' people in various ways, or, in the case of 'mental disorders', 'triggering' vulnerabilities that are internal to the person.

Furthermore, such accounts still view the 'psychological' aspect of human beings as being contained in, or represented by, an entity referred to as the 'mind' (which may or may not be conflated with the brain, depending on the account), and this 'mind' (or brain) generates various 'mental' or psychological phenomena such as thoughts, desires, obsessions, hallucinations, etc. It is this 'mind' which 'dysfunctions' and 'causes' the person to feel/think/act in ways which are considered to be 'ununderstandable[1]', in

[1] As was noted in Chapter One, this is a term coined by Karl Jaspers (1963, cited in Sass, 2002) a German phenomenological psychiatrist, to describe the kinds of 'psychopathologies' that were "closed to psychological comprehension" (Sass, 2002, p 251). Such suffering, in other words, was so bizarre it could only be caused by aberrations in the brain.

which case they are said to be suffering from a 'mental disorder', a concept which the majority of such accounts still accept without question.

In the account presented in this thesis it was suggested that the feelings/thoughts/actions which are 'symptomatic' of the various 'mental disorders' listed in the DSM-IV-TR (American Psychiatric Association, 2000) are, in fact, completely understandable if they are seen as being emergent from our continual personal and embodied enmeshment within our social world, rather than as arising out of the various processes occurring *within* us (whether that be our neurochemistry or our 'mental mechanisms' or an 'interaction' between them).

This means that while organismic and molecular level factors will, due the fact we are biophysically embodied, be inevitably involved in the genesis and the experience of psychological suffering, they are not, in and of themselves, the *cause* of such suffering. Furthermore, it has been argued in this thesis that it is person level factors, particularly those which occur within, and emerge out of, our interactions with our primary care-giver, which give particular shape to our 'sufferings' due to their effects on the early stages of the emergence of the various 'senses of self' (as outlined in Chapter Three) which comprise our personal being.

This means that the feelings/thoughts/behaviours which are conceptualised as 'mental disorder' are as much part of our personal being as any other aspect of us; they are not 'other', they are not 'disease', 'illness' or 'dysfunction'. Indeed, as was illustrated in Chapters Five and Six, such feelings/thoughts/behaviours almost always represent an adaptive response, at every level of our being, to the environmental contingencies people are faced with. Thus, when understood in its full context, the suffering conceptualised as 'mental illness'/'mental disorder' can be seen as the very understandable responses of the embodied person to what is happening to them, rather than 'ununderstandable' dysfunctions, aberrations and pathological processes of the 'mind' (or brain).

Thus this analysis places the kind of psychological suffering conceptualised as 'mental disorder' on a continuum with all other human experiences and means that the 'symptoms' of psychiatry's various 'mental disorders' are meaningful expressions of distress rather than meaningless 'noise' from dysfunctional brains or minds.

Obviously such an analysis has major implications for the ways in which those who are considered to be 'mentally ill' are treated, both by society and by 'mental health professionals', most of whom are still viewing such suffering through a 'Dysfunctional Mind Account' lens. The analysis presented in this thesis suggests that the kind of suffering conceptualised as 'mental disorder' should not be seen as representing a

dysfunctioning 'mind' or brain and thus should not be seen as a problem that should be dealt with from within a scientific-medical paradigm. Indeed, it is suggested that such a paradigm, with its determinedly individualistic focus, is entirely the wrong one to turn to if one is interested in preventing, alleviating, or simply helping people to understand and live more comfortably with, the experiences conceptualised as symptomatic of 'mental disorder'.

As was noted in Chapter Six, while the analysis presented in this thesis focused primarily on the role of early relational problems in the genesis of psychological suffering, such relational problems do not occur because of 'dysfunctional' processes 'within' the individuals involved, but because of socio-cultural and economic factors which are forcing human beings to live in an increasingly socially fragmented world which is profoundly at odds with our 'nature' (Schumaker, 2001; Smail, 1987; Small, 1998; Taylor, 2002).

As a number of theorists are increasingly arguing, it is essentially this fragmentation and isolation, at every point in a person's lifeline – from the very earliest interactions with their first care-giver onwards – which generates and maintains the kinds of suffering conceptualised as 'mental disorder' (e.g., Bentall, 2004; Eckersley, 2004; Perry, 2001; Smail, 1987, 1993; Schumaker, 2001; Seligman, 1990). It is suggested that these more distal or macro-social factors must be acknowledged and changed before any progress can be made towards preventing, or even alleviating, the kinds of psychological suffering conceptualised as 'mental disorder'.

As was discussed in Chapter Six, social and economic factors in modern Western societies have structured child-rearing so that most, if not all, of the responsibility for bringing up the next generation rests with the biological parents, and, in many cases, with the mother. This isolates parents from the rest of the social group who would have, in more traditional societies, shared the child-rearing responsibilities, and leaves them, essentially, to parent alone.

This 'privatisation' of child-rearing, as was discussed in Chapter Six, particularly in conjunction with other social and financial pressures, can result in less than optimal early relational experiences for offspring which, it was suggested, contribute to a generalised vulnerability to the kinds of psychological suffering endemic to, and rapidly increasing in, Western and Westernising societies (Good & Kleinman, 1985; Schumaker, 2001; Seligman, 1990).

It was also suggested in Chapter Six that social and economic forces which structure modern Western societies not only create vulnerabilities to psychological suffering, but it also provide fertile ground, due to the increased likelihood of loneliness

and social isolation, for the precipitation and the maintenance of such suffering. As has been noted a number of times in this thesis, human beings are profoundly social creatures, and they find aloneness and social alienation intolerable at every level of their being – molecular, organismic and personal.

As Schumaker (2001, p 7) points out,

> All functional cultures take heed of our inherently social nature. They operate in conjunction with this aspect of human nature and provide pathways whereby members can become united in satisfying ways.

While psychological suffering is undeniably a personal experience, we must ultimately look beyond the personal, to the social and material environment out of which all of our 'personhoods' emerge, if we truly wish to understand, alleviate and perhaps even prevent such suffering.

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